AGENDA
MEETING OF THE
EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

Tuesday, June 17, 2025 – 5:30 pm

El Camino Hospital | 2500 Grant Road, Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT:

1-669-900-9128, MEETING CODE: 952 0907 8746#. No participant code. Just press #.

To watch the meeting, please visit:

ECHD Meeting Link

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: In the event that there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1.	**CALL TO ORDER/ROLL CALL**	George Ting, M.D., Board Chair	Information	**5:30**
2.	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	George Ting, M.D., Board Chair	Possible Motion	**5:30**
3.	**SALUTE TO THE FLAG**	George Ting, M.D., Board Chair	Information	**5:30**
4.	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	George Ting, M.D., Board Chair	Information	**5:30**
5.	**PUBLIC COMMUNICATION** a. Oral Comments *This opportunity is provided for persons desiring to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. Written Public Comments *Comments may be submitted by mail to the El Camino Hospital District Board of Directors at 2500 Grant Road, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted to the agenda.*	George Ting, M.D., Board Chair		**5:30**

A copy of the agenda for the Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting.
In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
6.	**CONSENT CALENDAR** *Items removed from the Consent Calendar will be considered separately.* a. Approve Minutes of the Open Session of the District Board Meeting (05/20/2025) b. Approve FY26 Pacing Plan c. Approve Resolution 2025-07: Setting the Meeting dates for FY26 d. Receive Period 10 Financial Report e. Receive FY25 Pacing Plan f. Receive FY25 ECHD Action Tracker g. Receive June 2025 ECHD Sponsorships Report	George Ting, M.D., Board Chair	**Motion Required**	**5:30 – 5:35**
7.	**COMMUNITY BENEFIT SPOTLIGHT:** **DAVID MINETA, CEO** **MOMENTUM FOR HEALTH** Adopt Resolution 2025-06	George Ting, M.D., Board Chair	**Motion Required**	**5:35 – 5:50**
8.	**APPOINTMENT OF LIAISON TO THE COMMUNITY BENEFIT ADVISORY COUNCIL**	George Ting, M.D., Board Chair	**Motion Required**	**5:50 – 5:55**
9.	**ECHD COMMUNITY BENEFIT** - FY26 Community Benefit Plan (Avenidas)	Dan Woods, CEO Jon Cowan, Executive Director, Government Relations and Community Partnerships	**Motion Required**	**5:55 – 6:00**
10.	**ECHD COMMUNITY BENEFIT** - FY26 Community Benefit Plan	Dan Woods, CEO Jon Cowan, Executive Director, Government Relations and Community Partnerships	**Motion Required**	**6:00 – 6:20**
11.	**ECHD STRATEGIC FRAMEWORK** - Population Health Update	Dan Woods, CEO Jon Cowan, Executive Director, Government Relations and Community Partnerships	Discussion	**6:20 – 6:40**
12.	**RECOMMENDATION FOR VACCINATION PROGRAM**	Shreyas Mallur, MD Jon Cowan, Executive Director, Government Relations and Community Partnerships	Discussion	**6:40 – 6:45**

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
13.	**APPROVE FY26 OPERATING BUDGET – ECHD AND EL CAMINO HOSPITAL & AFFILIATES**	Carlos Bohorquez, CFO	**Motion Required**	**6:45 – 7:15**
14.	**ESTABLISHING TAX APPROPRIATION LIMIT FOR FY26 (GANN LIMIT)** Adopt Resolution 2025-08	Michael Walsh, Controller	**Motion Required**	**7:15 – 7:20**
15.	**APPROVE DISTRICT CAPITAL OUTLAY FUNDS**	Ken King, Chief Administrative Services Officer	**Motion Required**	**7:20 – 7:30**
16.	**DISTRICT BOARD OFFICERS ELECTION** a. Chair b. Vice-Chair c. Secretary/Treasurer *Appended on 6/16/25 to include Historical Officer Data	George Ting, M.D., Board Chair	**Motion Required**	**7:30 – 7:45**
17.	**RECESS TO CLOSED SESSION**	George Ting, M.D., Board Chair	**Motion Required**	**7:45 – 7:46**
18.	**APPROVE MINUTES OF THE CLOSED SESSIONS OF THE DISTRICT BOARD MEETINGS** a. Minutes of the Closed Session of the District Board Meeting (05/20/2025) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	George Ting, M.D., Board Chair	**Motion Required**	**7:46 – 7:47**
19.	**EXECUTIVE SESSION** *Report involving Gov't Code Section 54957 for discussion and report on personnel performance matters – CEO.*	George Ting, M.D., Board Chair	Discussion	**7:47 – 7:57**
20.	**ADJOURN TO OPEN SESSION**	George Ting, M.D., Board Chair	**Motion Required**	**7:57 – 7:58**
21.	**RECONVENE OPEN SESSION/ REPORT OUT**	George Ting, M.D., Board Chair	Information	**7:58 – 7:59**
22.	**BOARD ANNOUNCEMENTS**	George Ting, M.D., Board Chair	Information	**7:59– 8:05**
23.	**ADJOURNMENT**	George Ting, M.D., Board Chair	**Motion Required**	**8:05 pm**

Appendix

Upcoming Meetings: September 9, 2025; October 14, 2025; February 10, 2026; March 10, 2026; May 19, 2026; June 23, 2026

El Camino Healthcare District Board of Directors
Open Session Meeting Minutes
Tuesday, May 20, 2025

El Camino Hospital | Sobrato Boardroom 1 | 2500 Grant Road, Mountain View, CA

Board Members Present
George O. Ting, MD, Chair
Carol A. Somersille, MD, Vice Chair
John Zoglin, Secretary/Treasurer
Peter C. Fung, MD
Julia E. Miller

Board Members Absent
None

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Theresa Fuentes, CLO
Ken King, CAO
Mark Klein, CCMO
Shreyas Mallur, MD, CQO
Deb Muro, CIO**
Jon Cowan, Executive Director, Government Relations and Community Partnerships

Others Present (cont.)
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards,

***Via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	Chair Ting called to order the open session of the Regular Meeting of the El Camino Healthcare District Board of Directors (the "Board") at 5:30 p.m. and reviewed the logistics for the meeting. A verbal roll call was taken; Directors Fung, Miller, Somersille, Ting, and Zoglin were present, constituting a quorum.	***Call to Order at 5:30 p.m.***
2. CONSIDER AB 2449 REQUESTS	Chair Ting asked if any members of the Board are appearing remotely per AB 2449. None were noted.	
3. SALUTE TO THE FLAG	Chair Ting asked Director Fung to lead the Pledge of Allegiance.	
4. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Ting asked if any Board members had a conflict of interest with any of the items on the agenda. No conflicts were noted.	
5. PUBLIC COMMUNICATION	Chair Ting asked if there were any members of the public with comments for any items not listed on the agenda. There were no members of the public present.	
6. CONSENT CALENDAR	Chair Ting asked if there were any items the Board wanted to remove for discussion. There were no items removed. **Motion:** To approve the items on the consent calendar. **Movant:** Miller **Second**: Somersille **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Consent calendar approved.*** *- Minutes of the Open Session of the District Board Meeting (03/18/2025)* *- Minutes of the Open Session of the Special Site Visit Meeting of the District Board (03/28/2025)*

7. PUBLIC HEARING TO CONSIDER ADOPTION OF A RESOLUTION INCREASING BOARD MEMBER COMPENSATION FROM $115.50 PER MEETING TO $121.28 PER MEETING	The board held a public hearing on proposed Resolution 2025-05, increasing the per-meeting compensation for board members from $115.50 to $121.28, effective July 19, 2025. Director Zoglin inquired whether the increase should be postponed until after the next election, but other directors noted that annual adjustments were typical regardless of election cycles. There was a robust conversation about the breadth of meetings covered under the policy, with some directors questioning whether certain social or informal gatherings should qualify. A consensus emerged that the policy language was sufficient and the issue lay in consistent application rather than definition. **Motion:** To adopt Resolution 2025-05 increasing the per-meeting compensation for board members from $115.50 to $121.28. **Movant:** Somersille **Second**: Miller **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None **Motion:** To approve the revised ECHD Compensation Policy **Movant:** Somersille **Second**: Miller **Ayes:** Fung, Miller, Somersille, Ting **Noes**: Zoglin **Abstentions**: None **Absent**: None **Recused**: None	***Resolution 2025-05 was adopted.*** *- Per meeting compensation will be $121.28, effective July 19, 2025* ***Revised ECHD Compensation Policy was approved.***
8. ECHD COMMUNITY BENEFIT	Mr. Cowan shared preliminary plans for the FY26 Community Benefit budget, including how to allocate up to $10 million in grant funding. Directors praised staff for their innovative proposals, especially those focused on supporting college-aged individuals and building a pipeline for healthcare careers. Several directors raised concerns about long-term impact and sustainability, with differing views on whether to maintain reserves or fully allocate funds. Director Zoglin emphasized the importance of spending strategically rather than committing to one-time expenditures. Director Somersille, who serves as liaison to the Community Benefit Advisory Council, urged generosity in two-year grant funding and supported a thoughtful, impact-driven approach. Staff was asked to return in June with distilled options for a vote, along with a comprehensive population health needs analysis.	

9. RECEIVE ECHD FY25 FINANCIAL REPORT	Mr. Bohorquez presented the FY25 Period 9 financials, highlighting strong overall performance. The consolidated enterprise reported total operating revenue of $1.273 billion, exceeding budget by 3% and showing 10% growth year-over-year. Expenses remained close to budget, with physician-related professional fees running slightly higher. Operating income and non-operating income outpaced budget expectations. For the District specifically, a variance in revenue due to the timing of property tax and IGT receipts was noted, but these are expected to normalize by fiscal year-end. Directors complimented management on maintaining stability amid inflation and workforce challenges, characterizing the leadership team as high-performing and mission-aligned. **Motion:** To receive period 9 financial report **Movant:** Somersille **Second**: Zoglin **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Period 9 Financial report received.***
10. REVIEW OF PROPOSED DISTRICT CAPITAL OUTLAY FUNDS	The board reviewed proposed allocations for the District's FY23 and FY24 capital outlay funds, with a focus on whether to direct $13 million in unallocated resources toward existing hospital capital projects. Mr. King explained that these funds are intended to support hospital-approved projects, not to initiate new ones, and provided background on recent investments, including the Women's Hospital Expansion and Mountain Campus Completion. Directors expressed interest in evaluating alternative uses, particularly around real estate acquisitions that could support long-term community health priorities, such as workforce or affordable housing. Director Somersille emphasized the need for specific options and planning related to social determinants of health. Director Miller questioned the internal vetting process and requested additional details on the project selection process. Mr. Bohorquez clarified that all projects undergo rigorous approval through the hospital's Finance Committee and Hospital Board. Several board members stressed the importance of transparency, alignment with District priorities, and strategic planning. Mr. King agreed to bring back a recommendation for allocation of FY23 funds at the next meeting and the board requested a future strategic discussion about the hospital's broader real estate portfolio at a future hospital board meeting.	***Action:*** *Staff to pace a strategic closed session discussion about the hospital and district's real estate portfolio and development plans with the Hospital Board*
11. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 7:24 p.m. **Movant:** Miller **Second**: Somersille **Ayes:** Fung, Miller, Somersille, Ting, Zoglin	***Recessed to closed session at 7:24 p.m.***

	Noes: None **Abstentions**: None **Absent**: None **Recused**: None	
12. AGENDA ITEM 15: CLOSED SESSION REPORT OUT	The open session was reconvened at **7:32 p.m.** by Chair Ting. Agenda Items 12-14 were addressed in closed session. Mr. Fernandez reported that during the closed session, the ECHD board approved the closed session minutes of the prior meeting.	***Reconvened open session at 7:32 p.m.***
13. AGENDA ITEM 16: COMMUNITY VACCINATION PROGRAM	The board explored the idea of launching a community vaccination initiative, particularly in response to recent measles outbreaks. Dr. Miller suggested offering common immunizations such as MMR and COVID-19. Dr. Mallur reported that the County is seeking healthcare partners and outlined a three-tier response strategy that includes case detection, contact testing, and vaccinations. El Camino is positioned to support all three layers. Directors discussed whether to include additional common vaccines and emphasized the need to follow evolving medical guidance. Director Fung raised questions about the effectiveness of certain vaccines and recommended caution. The board agreed to have Dr. Mallur return with a short recommendation at the next meeting and to continue coordinating with the County.	***Action:*** *Staff to return at next meeting with a recommendation for a community vaccination program.*
14. AGENDA ITEM 17: ECHD COMMUNICATIONS STRATEGY CONCEPT	Mr. Klein presented the district's new communications strategy, centered on producing a twice-yearly, magazine-style newsletter for residents. This approach includes hiring a professional medical writer to ensure clarity and accessibility of health information. Directors were supportive of the plan, commending the emphasis on transparency and community engagement. Director Miller asked about the budget, the data regarding the efficacy of print and the necessity to outsource these items. Director Zoglin requested detailed cost breakdowns, including fees and mailing expenses. Director Fung expressed strong support for the strategy. The board approved moving forward and requested a full accounting of costs at a future meeting. **Motion:** To approve the ECHD Communications Strategy Concept **Movant:** Fung **Second**: Somersille **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***ECHD Communications Strategy Concept Approved.*** ***Action:*** *Staff to provide a full cost breakdown for new communication strategy.*
15. AGENDA ITEM 18: BOARD ANNOUNCMENTS	Director Fung noted that it was stroke awareness month and urged people to know the symptoms. Chair Ting noted that time	***Action:*** *Staff to add more time to*

	had been exceeded and asked staff to extend the time on the next agenda.	*next agenda for full discussions.*
16. AGENDA ITEM 19: ADJOURNMENT	**Motion**: To adjourn at 7:54 p.m. **Movant:** Miller **Second**: Ting **Ayes:** Fung, Miller, Somersille, Ting, Zoglin **Noes**: None **Abstentions**: None **Absent**: None **Recused**: None	***Meeting adjourned at 7:54 p.m.***

Attest as to the approval of the foregoing minutes by the Board of Directors of El Camino Healthcare District:

_____
John Zoglin
Secretary/Treasurer, ECHD Board

Prepared by: Tracy Fowler, Director, Governance Services
Reviewed by: John Zoglin, Secretary/Treasurer, ECHD Board and Theresa Fuentes, Chief Legal Officer

EL CAMINO HEALTHCARE DISTRICT
FY2026 PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
COMMUNITY BENEFIT												
Spotlight Recognition				✓				✓	✓			
CB Year-End Report				✓								
CBAC Policy – Annual Approval				✓								
CB Plan Study Session											✓	
CB Mid-Year Metrics											✓	
Approval of CB Plan												✓
Grant Partner Site Visit				✓		✓		✓	✓			
COMPLIANCE												
Financial Audit – Consolidated ECH District Financials				✓								
Approve Hospital Audit				✓								
DISTRICT REAL ESTATE												
Real Estate Update				✓					✓			
District Capital Outlay											✓	✓
EXECUTIVE PERFORMANCE												
CEO Performance Review			✓									
FINANCE												
Financials				✓				✓	✓			✓
Budget											✓	✓
Tax Appropriation (Gann limit)												✓
GOVERNANCE												
Appoint Ad Hoc Committee & Advisors for ECHB Director Election				✓								
ECHB Director Ad Hoc Committee Update				✓				✓	✓		✓	
Appointment/Re-appointment of El Camino Hospital Board Director								✓ Incumbent			✓ New	
Review Process for ECHD Board Officer Election (*Odd Years*)												
ECHD Board Officer Election (*Odd Years*)												
Appointment of Liaison to the Community Benefit Advisory Council												✓
Pacing Plan & Meeting Dates												✓
Oath of Office for Newly Elected/Re-elected Directors (*Even Years*)												
Possible Appointment to ECHB Board for Newly Elected Directors (*Even Years*)												
ECHD Board Self-Evaluation			✓									
ECHD Bylaws Review								✓				
STRATEGY												
Population Health Strategy Update				✓					✓			

Updated 06/06/2025

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District Board of Directors
From: George Ting, MD, Chair
Date: June 17, 2025
Subject: Proposed Resolution 2025-08: Setting Meeting Dates for FY26

Recommendation:

To approve Proposed Resolution 2025-07: Setting Meeting Dates for FY26

Summary:

1. Situation: Pursuant to California Government Code Section 54954(a) "Each legislative body of a local agency, except for advisory committees or standing committees, shall provide, by ordinance, resolution, bylaws or by whatever other rule is required for the conduct of business by that body, the time and place for holding regular meetings. "

2. Authority: Article VI (3)(a) of the District Bylaws state: "Regular meetings of the District Board shall be held without call on the date and at the time and place established, from time-to-time, by resolution of the District Board. The District Board may establish the date, time, and place of one (1) or more regular meetings in any such resolution."

3. Background: The District has routinely approved a Resolution adopting an annual meeting schedule. For the last several years, the Board has scheduled quarterly meetings in October, February, March, and June for the purpose of conducting the District Board's usual business with a September meeting primarily for the purpose of CEO assessment and a May meeting primarily for the purpose of reviewing the annual Proposed Community Benefit Plan. In election years, the District Board also schedules a December meeting for the purpose of administering the Oath of Office to Board members elected or re-elected in the November Election and for electing El Camino Hospital Board members. In FY24 the Board requested that quarterly site visits be incorporated into the meeting schedule to increase participation and transparency.

4. Outcomes: Meeting Schedule for FY26 established and provided to the public.

List of Attachments: Proposed Resolution 2025-07

Resolution 2025-07

Resolution of the Board of Directors of El Camino Healthcare District Establishing Meeting Dates and Time

RESOLVED, Article VI, Section 3(a) of the Bylaws of El Camino Healthcare District requires the Board to adopt a resolution setting meeting dates; be it further,

RESOLVED, that the meeting dates of the District Board for FY 2026 as stated on the attached Exhibit A; be it further,

RESOLVED, all meetings of the District Board shall be held at El Camino Hospital, 2500 Grant Road, Mountain View, California 94040, unless another location is identified on the meeting notice, which shall be posted at least 72 hours before the meeting or telephonically in accordance with State of California Executive Orders that may, from time to time, temporarily suspend certain provisions of the Ralph M. Brown Act requiring a physical meeting location.

RESOLVED, that the meeting dates shall be posted at El Camino Hospital, on the El Camino Healthcare District website and shall be mailed or e-mailed to all persons who have requested notice of EL Camino Healthcare District meetings in writing as of January 1 each year.

DULY PASSED AND ADOPTED at a Regular Meeting held on the 17th day of June, 2025 by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

By: _____
John Zoglin
Secretary/Treasurer, ECHD Board of Directors

EXHIBIT A

El Camino Healthcare District Board Meetings
Proposed FY2026 Dates

BOARD MEETING DATES
Tuesday, September 9, 2025
Tuesday, October 14, 2025
Friday, November 14, 2025 – Site Visit
Friday, December 5, 2025 – Site Visit
Friday, February 6, 2026 – Site Visit
Tuesday, February 10, 2026
Tuesday, March 10, 2026
Friday, March 20, 2026 – Site Visit
Tuesday, May 19, 2026
Tuesday, June 23, 2026

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: June 17, 2025
Subject: YTD FY2025 Financial Update (as of 4/30/2025)

Purpose:

To approve the Consolidated and Stand-Alone (District) Financials for YTD FY2025 (as of 4/30/2025).

Executive Summary – Consolidated Enterprise Financials (as of 4/30/2025):

Patient activity / volumes remain consistent across the enterprise which has yielded stable financial results through the first ten months of FY2025. The following are key financial KPIs:

Net Patient Revenue ($):	$1,359 million which is favorable to budget by $46 million / 3.5% and $130 million / 10.6% higher than in the same period last year.
Total Operating Revenue ($):	$1,424 million is favorable to budget by $54 million / 3.9% and $130 million / 10.0% higher than in the same period last year.
Operating Income ($):	$141 is favorable to budget by $32 million / 29.4% and $19 million / 15.6% higher than the same period last year.
Balance Sheet ($):	In the first ten months of FY2025 the net position increased by $250 million.

Executive Summary – Stand-Alone (District) Financials (as of 4/30/2025):

Total Operating Revenue ($):	$24 million is unfavorable to budget by $4 million / 12.9%. Unfavorable variance is attributed to timing of receipt of IGT and property tax funds.
Net Income ($):	$12 million is unfavorable to budget by $3 million / 17.7%. Unfavorable variance is attributed delay in IGT and property tax funds.

Recommendation:

- Recommend the District Board of Directors approve the Consolidated and Stand-Alone (District) YTD FY2025 financials.

List of Attachments:

- Consolidated and Stand-Alone (District) Financials – YTD FY2025 (as of 4/30/2025)

Dedicated to improving the health and well being of the people in our community.

Board - Finance Presentation
Fiscal Year 2025
7/1/2024 - 4/30/2025

Carlos Bohorquez, CFO

El Camino Healthcare District Board of Directors Meeting
June 17, 2025

Table of Contents

ECHD Consolidated Financial Statements (Includes El Camino Hospital)

ECHD Stand-Alone Financial Statements

NOTE: Accounting standards require that audited financial statements for El Camino Healthcare District be presented in consolidated format, including El Camino Hospital and its controlled affiliates. In an effort to help ensure public accountability and further ensure the transparency of the District's operations, the District also prepares internal, "Stand-Alone" financial statements which present information for the District by itself.

El Camino Healthcare District

Consolidated Comparative Balance Sheet ($ Millions)

(Includes El Camino Hospital)

	Apr 30, 2025	June 30, 2024 Audited w/o Eliminations
ASSETS		
Current Assets		
Cash & Investments	$439	$332
Patient Accounts Receivable, net	227	214
Other Accounts and Notes Receivable	50	44
Inventories and Prepaids	47	56
Total Current Assets	**763**	**645**
Board Designated Assets		
Foundation Reserves	17	23
Community Benefit Fund	30	26
Operational Reserve Fund [1]	212	212
Workers Comp, Health & PTO Reserves	77	73
Facilities Replacement Fund [2]	618	565
Catastrophic & Malpractice Reserve [3]	38	35
Total Board Designated Assets	**993**	**935**
Non-Designated Assets		
Funds Held By Trustee [4]	34	40
Long Term Investments	693	669
Other Investments	50	38
Net Property Plant & Equipment	1,333	1,327
Deferred Outflows of Resources	42	43
Other Assets	253	230
Total Non-Designated Assets	**2,406**	**2,346**
TOTAL ASSETS	**$4,161**	**$3,925**

	Apr 30, 2025	June 30, 2024 Audited w/o Eliminations
LIABILITIES & FUND BALANCE		
Current Liabilities		
Accounts Payable & Accrued Exp [5]	$177	$177
Bonds Payable - Current	15	14
Bond Interest Payable	9	13
Other Liabilities	23	15
Total Current Liabilities	**223**	**218**
Deferred Revenue	**2**	**1**
Deferred Revenue Inflow of Resources	**92**	**93**
Long Term Liabilities		
Bond Payable	523	540
Benefit Obligations	36	36
Other Long-term Obligations	27	30
Total Long Term Liabilities	**587**	**605**
Fund Balance		
Unrestricted	3,011	2,790
Minority Interest	-	(1)
Board Designated & Restricted	246	219
Capital & Retained Earnings	0	0
Total Fund Balance	**3,257**	**3,007**
TOTAL LIAB. & FUND BAL.	**$4,161**	**$3,925**

Note: Totals may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Consolidated Comparative Statement of Revenues & Expenses ($ Millions)

Year-to-Date through April 30, 2025

(Includes El Camino Hospital)

	Actual	Budget	Fav (Unfav) Variance	Prior YTD FY Actual
Net Patient Revenue [6]	1,359	1,312	46	1,229
Other Operating Revenues	65	57	8	65
Total Operating Revenues	**1,424**	**1,369**	**54**	**1,294**
Wages and Benefits	729	723	(6)	661
Supplies	196	189	(7)	176
Purchased Services	229	215	(14)	197
Other	43	49	6	54
Depreciation	71	71	0	69
Interest	15	14	(1)	15
Total Operating Expense [7]	**1,282**	**1,261**	**(22)**	**1,172**
Operating Income	**141**	**109**	**32**	**122**
Non-Operating Income [8]	91	66	26	126
Net Income	**233**	**175**	**58**	**248**

Note: Totals or variances may not agree due to rounding. See page 5 for footnotes.

El Camino Healthcare District

Notes to Consolidated Financial Statements

Current FY2025 Actual to Budget

(Includes El Camino Hospital)

1) A 60 day reserve of expenses based on this fiscal year's Hospital budget.
2) The current period Facilities Replacement Fund is comprised of ($ Millions):

ECH Capital Replacement Fund (i.e. Funded Depr.)	$514
ECH Women's Hospital Expansion	45
ECHD Appropriation Fund (aka: Capital Outlay)	27
ECH Campus Completion Project	32
	$618

3) The current period Catastrophic & Malpractice Fund is comprised of ($ Millions):

ECH Catastrophic Fund (aka: Earthquake Fund)	$36
ECH Malpractice Reserve	2
	$38

4) Funds Held by Trustee now only reflect the GO funds of the District.
5) No difference.
6) The difference is not significant.
7) The difference is not significant.
8) The significant increase in non-operating income was due to strong investment returns in the first half of the fiscal year.

El Camino Healthcare District

Stand-Alone Comparative Balance Sheet ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	Apr 30, 2025	Audited June 30, 2024		Apr 30, 2025	Audited June 30, 2024
ASSETS			**LIABILITIES & FUND BALANCE**		
Cash & cash equiv [1]	$19,673	$28,310	Accounts payable	$5	$0
Short term investments [1]	5,036	533	Current portion of bonds	3,411	3,398
Due fm Retiree Health Plan [2]	0	0	Bond interest payable [10]	4,252	5,116
S.C. M&O Taxes Receivable [3]	0	0	Other Liabilities	325	276
Other current assets [3a]	55	55			
Total current assets	$24,764	$28,898	**Total current liabilities**	$7,994	$8,790
Operational Reserve Fund [4]	1,500	1,500			
Capital Appropriation Fund [5]	27,324	24,574			
Capital Replacement Fund [6]	5,607	5,607	Deferred income	78	57
Community Partnership Fund [7]	12,364	8,501	Bonds payable - long term	95,517	98,942
Total Board designated funds	$46,795	$40,181	**Total liabilities**	**$103,588**	**$107,789**
Funds held by trustee [8]	**$33,741**	**$40,216**	**Fund balance**		
Capital assets, net [9]	**$10,639**	**$10,644**	Unrestricted fund balance	$83,839	$79,188
			Restricted fund balance	(71,488)	(67,038)
			Total fund balance [11]	**$12,351**	**$12,150**
TOTAL ASSETS	**$115,939**	**$119,939**	**TOTAL LIAB & FUND BALANCE**	**$115,939**	**$119,939**

Note: Totals may not agree due to rounding. See page 9 for footnotes.

El Camino Healthcare District

YTD Stand-Alone Stmt of Revenue and Expenses ($ Thousands)

Comparative Year-to-Date April 30, 2025

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

		Actual	Current Year Budget	Variance	Prior Full Year Actual
	REVENUES				
(A)	Ground Lease Revenue [12]	$ 96	93	$ 3	$ 112
(B)	Redevelopment Taxes [13]	-	150	(150)	246
(B)	Unrestricted M&O Property Taxes [13]	11,450	13,150	(1,700)	11,048
(B)	Restricted M&O Property Taxes [13]	12,544	9,875	2,669	14,278
(B)	G.O. Taxes Levied for Debt Service [13]	2,250	5,333	(3,083)	7,920
(B)	IGT/PRIME Medi-Cal Program [14]	(4,885)	(2,500)	(2,385)	(6,093)
(B)	Investment Income (net)	2,775	1,723	1,052	1,806
(B)	Other income	-	-	-	-
	TOTAL NET REVENUE	24,230	27,824	(3,594)	29,317
	EXPENSES				
(A)	Wages & Benefits [15]	28	18	(10)	16
(A)	Professional Fees & Purchased Svcs [16]	882	758	(124)	470
(A)	Supplies & Other Expenses [17]	26	35	9	57
(B)	G.O. Bond Interest Expense (net) [18]	4,476	4,732	256	5,118
(B)	Community Partnership Expenditures [19]	7,083	8,015	932	7,473
(A)	Depreciation / Amortization	4	4	-	5
	TOTAL EXPENSES	12,499	13,562	1,063	13,139
	NET INCOME	$ 11,730	$ 14,261	$ (2,531)	$ 16,177

(A) Operating Revenues & Expenses

(B) Non-operating Revenues & Expenses

	RECAP STATEMENT OF REVENUES & EXPENSE	
(A)	Net Operating Revenues & Expenses	$ (844)
(B)	Net Non-Operating Revenues & Expenses	12,574
	NET INCOME	$ 11,730

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Comparative YTD Stand-Alone Stmt of Fund Balance Activity ($ Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

	April 30, 2025	June 30, 2024
Fiscal year beginning balance	**$ 12,150**	**$ 935**
Net income year-to-date	$ 11,730	$ 16,177
Transfers (to)/from ECH:		
IGT/PRIME Funding [20]		$ 6,167
Capital Appropriation projects [21]	$ (11,528)	(11,129)
Fiscal year ending balance	**$ 12,351**	**$ 12,150**

Note: Totals may not agree due to rounding. See page 10 for footnotes.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(1) Cash & Short Term Investments – The decrease from June 30 is due to the timing of M&O receipts being received in the current year.

(2) Due from Retiree Health Plan – The monies due from Trustee for District's Retiree Healthcare Plan.

(3) S.C. M&O Taxes Receivable – No change.

(3a) Other Current Assets – No change.

(4) Operational Reserve Fund – Starting in FY 2014, the Board established an operational reserve for unanticipated operating expenses of the District.

(5) Capital Appropriation Fund – The increase is due to the establishment of the year-end FY23 funding set aside for the completion of the MV Campus.

(6) Capital Replacement Fund – Formerly known as the Plant Facilities Fund (AKA - Funded Depreciation) which reserves monies for the major renovation or replacement of the portion of the YMCA (Park Pavilion) owned by the District.

(7) Community Partnership Fund – This fund retains unrestricted (Gann Limit) funds to support the District's operations and primarily to support its Community Partnership Programs.

(8) Funds Held by Trustee – Funds from General Obligation tax monies, being held to make the debt payments when due.

(9) Capital Net Assets - The land on which the Mountain View Hospital resides, a portion of the YMCA building, property at the end of South Drive (currently for the Road Runners operations), and a vacant lot located at El Camino Real and Phyllis.

(10) Bond Interest Payable – The decrease is a timing issue and will increase in subsequent months to be comparable to the June 30 amount.

(11) Fund Balance – The positive fund balance is a result of the General Obligation bonds which assisted in funding the replacement hospital facility in Mountain View. Accounting rules required the District to recognize the obligation in full at the time the bonds were issued ; receipts from taxpayers will be recognized in the year they are levied.

El Camino Healthcare District

Notes to Stand-Alone Financial Statements

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

(12) Other Operating Revenue – Lease income from El Camino Hospital for its ground lease with the District.

(13) Taxes: Redevelopment, M&O, G.O. – Tax receipts during the period. G.O. Taxed Levied for Debt will catch up in January as the semi-annual disbursement will occur from the County.

(14) IGT/PRIME Expense – Payments in support of the PRIME or IGT programs.

(15) Wages & Benefits – IRS regulations require that board of directors be compensated as employees.

(16) Professional Fees & Services – Actual detailed below:

• Community Partnership Support from ECH (54% of SW&B)	$ 298
• Santa Clara County Election	450
• Communications Support	82
• Newsletter Printing & Postage	48
• Other	4
	$ 882

(17) Supplies & Other Expenses – Actual detailed below:

• LAFCO	18
• 2025 CSDA Membership	10
• Other	(2)
	$ 26

(18) G.O. Bond Interest Expense – It is to be noted that on March 22, 2017 the District refunded $99M of its remaining $132M 2006 G.O. bond issue. Refunding of the 2006 G.O. debt, given current interest rates, caused a net present value savings of $7M.

(19) Community Partnership Expenditures – Starting in FY2014, the District is directly operating its Community Partnership Program at the District level. This represents amounts expended to grantees and sponsorships thus far in this fiscal year. Note the major payments to recipients are made in August & January of the fiscal year.

(20) IGT/PRIME Funding – Transfers from ECH for participation in the PRIME or IGT program thus far in FY 2025.

(21) Capital Appropriation Projects Transfer – Net increase of last year transferred out and establishing current year.

El Camino Healthcare District

Sources & Uses of Tax Receipts ($Thousands)

*These financial statements **exclude** the District's El Camino Hospital Corporation and its controlled affiliates*

Sources of District Taxes	**4/30/25**
(1) Maintenance and Operation and Government Obligation Taxes	$26,244
(2) Redevelopment Agency Taxes	-
Total District Tax Receipts	**$26,244**
Uses Required Obligations / Operations	
(3) Government Obligation Bond	2,250
Total Cash Available for Operations, CB Programs, & Capital Appropriations	**23,994**
(4) Capital Appropriation Fund – Excess Gann Initiative Restricted*	12,544
Subtotal	**11,450**
(5) Operating Expenses (Net)	844
Subtotal	**10,606**
(6) Capital Replacement Fund (Park Pavilion)	5
Funds Available for Community Partnership Programs	**$10,601**
*Gann Limit Calculation for FY2025	$10,946

(1) M&O and G.O. Taxes	• Cash receipts from the 1% ad valorem property taxes and Measure D taxes
(2) Redevelopment Agency Taxes	• Cash receipts from dissolution of redevelopment agencies
(3) Government Obligation Bond	• Levied for debt service
(4) Capital Appropriation Fund	• Excess amounts over the Gann Limit are restricted for use as capital
(5) Operating Expenses	• Expenses incurred in carrying out the District's day-to-day activities
(6) Capital Replacement Fund	• Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion)

Q & A

EL CAMINO HEALTHCARE DISTRICT
FY2025 PACING PLAN / MASTER CALENDAR

AGENDA ITEM	Q1			Q2			Q3			Q4		
	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
COMMUNITY BENEFIT												
Spotlight Recognition				✓		✓		✓				
CB Year-End Report				✓								
CBAC Policy – Annual Approval				✓								
CB Plan Study Session											✓	
CB Mid-Year Metrics											✓	
Approval of CB Plan												✓
Grant Partner Site Visit				✓		✓		✓	✓			
COMPLIANCE												
Financial Audit – Consolidated ECH District Financials				✓								
Approve Hospital Audit				✓								
DISTRICT REAL ESTATE												
Real Estate Update				✓					✓			
District Capital Outlay											✓	✓
EXECUTIVE PERFORMANCE												
CEO Performance Review		✓										
FINANCE												
Financials				✓				✓	✓			✓
Budget											✓	✓
Tax Appropriation (Gann limit)												✓
GOVERNANCE												
Appoint Ad Hoc Committee & Advisors for ECHB Director Election		✓										
ECHB Director Ad Hoc Committee Update				✓				✓	✓		✓	
Appointment/Re-appointment of El Camino Hospital Board Director								✓ Incumbent			✓ New	
Review Process for ECHD Board Officer Election (*Odd Years*)											✓	
ECHD Board Officer Election (*Odd Years*)												✓
Appointment of Liaison to the Community Benefit Advisory Council												✓
Pacing Plan & Meeting Dates												✓
Oath of Office for Newly Elected/Re-elected Directors (*Even Years*)						✓						
Possible Appointment to ECHB Board for Newly Elected Directors (*Even Years*)						✓						
ECHD Board Self-Evaluation		✓										
ECHD Bylaws Review								✓				
STRATEGY												
Strategic Plan Update		✓		✓								

Updated 06/19/2024

FY25 ECHD MEETING FOLLOW UP ITEMS

Subject	Timing	Action	Status
May 2025 ECHD Meeting			
BOARD MEMBER COMPENSATION INCREASE	Next Report	Update the resolution and memo to include the actual date the increase goes into effect. (End of 60 days)	In progress
COMMUNITY BENEFIT	Next Meeting	Include comprehensive population health needs analysis of the healthcare district in June's meeting materials	Already planned and paced. In progress.
DISTRICT CAPITAL OUTLAY FUNDS	Off Agenda (for ECHB meeting)	Schedule a strategic closed session discussion about the hospital and district's real estate portfolio and development plans	Add to ECHB pacing plan. In progress
	Off Agenda	Confirm workforce survey and focus groups in May-June to better understand employee housing needs are included in real estate discussion.	In progress
COMMUNITY VACCINATION PROGRAM	Next Meeting	Prepare a short recommendation regarding measles vaccination program for next meeting	Paced for June 17 ECHD
	Future Meeting	Maintain communication with Santa Clara County health officers regarding measles outbreak preparedness and potential partnership. Look into data re: common, not esoteric vaccines.	In progress
ECHD COMMUNICATIONS	Future Meeting	Provide complete cost breakdown of the new communication strategy including all fees and production costs. Include mailing estimates	In progress
CLOSING COMMENTS	Next Meeting	Tracy to add time to next agenda to allow better time management	Paced for June 17 ECHD
March 2025 ECHD Meeting			
ECHD Community Benefit Funds	Next Meeting	Add review of Community Benefit Program to next agenda	COMPLETE

Updated 06/06/2025

Director Compensation Increase	Off Agenda	Resend link to Controller Page	COMPLETE
	Off Agenda	Send list of all compensation out to Directors	COMPLETE
	Next Meeting	Add compensation policy to next agenda	COMPLETE
	Off Agenda	Start the public notice process for compensation increase	COMPLETE
Retention Policy	Off Agenda	Notify the website team of new retention period	COMPLETE
Real Estate Strategy	Off Agenda	Add signage to the Phyllis property	In progress
	Next Meeting	Create a plan for Phyllis property with several options shared by the Board – mixed use, workforce housing, commercial use, lease to ECHB	In progress
	Next Meeting	Clarify legal definitions and constraints around various housing types (workforce, affordable, market-rate).	In progress – to be part of comprehensive real estate portfolio review at hospital board meeting
February 2025 ECHD Meeting			
ECHD Strategic Framework Update	Future Meeting	Add strategic framework – population health topic to June ECHD agenda.	Paced for June 17 ECHD
Closed Session Minutes	Next Meeting	Staff to present a district inventory of real estate assets.	COMPLETE
October 2024 ECHD Meeting			
Community Benefits	Future meeting	Staff to have Marketing review the ECHD logo for ways to increase visibility	COMPLETE

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Executive Director Government Relations & Community Partnerships
Date: June 17, 2025
Subject: Community Benefit Sponsorships

Purpose: To provide the Board with FY2025 ECHD Sponsorships in June 2025.

Summary:

1. Situation: Community Benefit Staff was asked to keep the Board informed regarding Community Benefit Sponsorships YTD.

2. Authority: Board reviewed and approved $90,000 for Sponsorships in the FY2025 Community Benefit Plan in June 2024.

3. Background:

- Sponsorship information and instructions are available on the District website.
- Requests include sponsorship packets that outline event date, purpose, levels of sponsorship and requirements for sponsor acknowledgement. These requests are reviewed throughout the year as they come in by Community Benefit Staff and the other designated departments that provide community sponsorships (*e.g.*, Marketing & Communications and Government Relations & Community Partnerships).
- Community Benefit-funded Sponsorships provide general support for health-related agencies improving the well-being of the community.
    - Community Benefit Sponsorships from June 1, 2025 **-** June 30, 2025 totaled **$0** (Sponsorships occur at different times throughout the year.)

EL CAMINO HEALTHCARE DISTRICT

RESOLUTION 2025 - 6

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HEALTHCARE DISTRICT REGARDING RECOGNITION OF SERVICE TO THE COMMUNITY

WHEREAS, the Board of Directors of the El Camino Healthcare District values and wishes to recognize the contribution of individuals who serve the District's community as well as individuals who exemplify the El Camino Healthcare District's mission and values.

WHEREAS, the Board wishes to honor and recognize David K. Mineta, for 10 years of service leadership as President and CEO of Momentum, for collaborating with El Camino Healthcare District to positively impact behavioral health in the District and advocating for behavioral health patients in the community.

El Camino Healthcare District and Momentum for Health began a partnership in 2011 to provide mental health services to those who do not have access to treatment because they cannot afford to pay for services and those who are uninsured.

Through Momentum's La Selva Community Clinic, the services address language barriers to accessing care and provide quick access to treatment and essential supportive services. This often includes managing patients with complex conditions with a safe step down for patients from high levels of care to transition to the next level of needed care.

WHEREAS, the Board acknowledges David K. Mineta for his commitment to providing psychiatric services and medication management to those who otherwise do not have access to this care. Through this grant program, under his leadership, Momentum has served approximately 900 community members with over 13,500 mental health services.

NOW THEREFORE BE IT RESOLVED that the Board does formally and unanimously pay tribute to:

David K. Mineta

IN WITNESS THEREOF, I have here unto set my hand this **17TH DAY OF JUNE, 2025.**

EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS:

Peter C. Fung, MD • Julia E. Miller • Carol A. Somersille, MD • George O. Ting, MD • John L. Zoglin

JOHN L. ZOGLIN
SECRETARY/TREASURER
EL CAMINO HEALTHCARE DISTRICT BOARD OF DIRECTORS

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Executive Director, Government Relations & Community Partnerships
Date: June 17, 2025
Subject: FY2026 Community Benefit Plan Recommended Grant for Avenidas

Purpose: To approve the FY2026 El Camino Healthcare District grant funding amount for **Avenidas Rose Kleiner Adult Day Health Program** and for its inclusion in the FY2026 El Camino Healthcare District Implementation Strategy Report and Community Benefit Plan (Community Benefit Plan)

Summary:

1. Situation: FY2026 Community Benefit Plan recommends funding Avenidas Rose Kleiner Adult Day Health program. Board member Dr. Peter Fung serves as a Board Member at Avenidas and will be recused from the discussion and vote of the FY2026 Avenidas grant.

2. Authority: Board approval of the FY2026 Community Benefit Plan (Dr. Peter Fung will be recused from the vote to approve the Avenidas grant recommendation).

3. Background:

- FY2026 Grant Application for Avenidas Rose Kleiner Adult Day Health Program:
  - Amount Requested: $74,200
  - Recommended for funding: $74,200
    - Total unfunded: $0

4. Other Reviews:

a. On April 24, 2025, Community Benefit Advisory Council (CBAC) provided funding recommendation consensus reflected in the FY2026 Application Index and Summaries.

b. On May 20, 2025, El Camino Healthcare District Board of Directors conducted a study session to review the FY2026 funding recommendations.

5. Outcomes: Approve the Avenidas grant as recommended or approve with amendments.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Executive Director, Government Relations & Community Partnerships
Date: June 17, 2025
Subject: FY2026 Community Benefit Plan

Purpose: To approve the FY2026 El Camino Healthcare District Implementation Strategy Report and Community Benefit Plan (Community Benefit Plan). To approve authority for Jon Cowan, Executive Director of Government Relations & Community Partnerships, to execute all grant agreements specified in the Community Benefit Plan.

Summary:

1. Situation: FY2026 Community Benefit Plan totals $9 million and includes funding recommendations for 59 applications, sponsorships and placeholder

2. Authority: Board approval of the FY2026 Community Benefit Plan

3. Background:

FY2026 Community Benefit Plan Summary

- **Grant Applications:**
  - 74 applications requested: $10,455,762
  - 59 applications recommended for funding: $8,413,000
    - Total unfunded: $2,042,762
- **Sponsorships:** $90,000
- ***Placeholder:** $497,000

*For the Placeholder, the recommendation includes three potential paths for the additional funds.

- **Option 1**: Reserve all placeholder funds for emergency FY2026 Community Benefit Grant funding by allowing an opportunity for grantees to request increased funds for those that fit high priority grant criteria.

- **Option 2:** Option 1, but with up to $50,000 reserved for programming focused on Community College health professions stipends.

- **Option 3:** Option 2, but with up to $50,000 reserved for Hospital employee-focused innovation programming.

FY2026 ECHD Total Plan Request: $9,000,000

Community Benefit Plan
Drawing from the findings in the 2025 Community Health Needs Assessment (CHNA), the FY2026 Implementation Strategy Report and Community Benefit Plan outlines goals and initiatives that address our community's most pressing health needs.

4. Other Reviews:

a. On April 24, 2025, Community Benefit Advisory Council (CBAC) provided funding recommendation consensus reflected in the FY2026 Application Index and Summaries.

b**.** On May 20, 2025, El Camino Healthcare District Board of Directors conducted a study session to review the FY2026 funding recommendations.

c. Following the May 20, 2025 study session, staff reviewed and provided additional recommendations as reflected in the total recommendation for funding.

5. Outcomes: Approve plan as recommended or approve plan with amendments

List of Attachments:

1. FY2026 ECHD Implementation Strategy Report and Community Benefit Plan (In Appendix)
2. FY2026 ECHD Proposal Index and Summaries (In Appendix)
3. Dual Funded Programs Summary

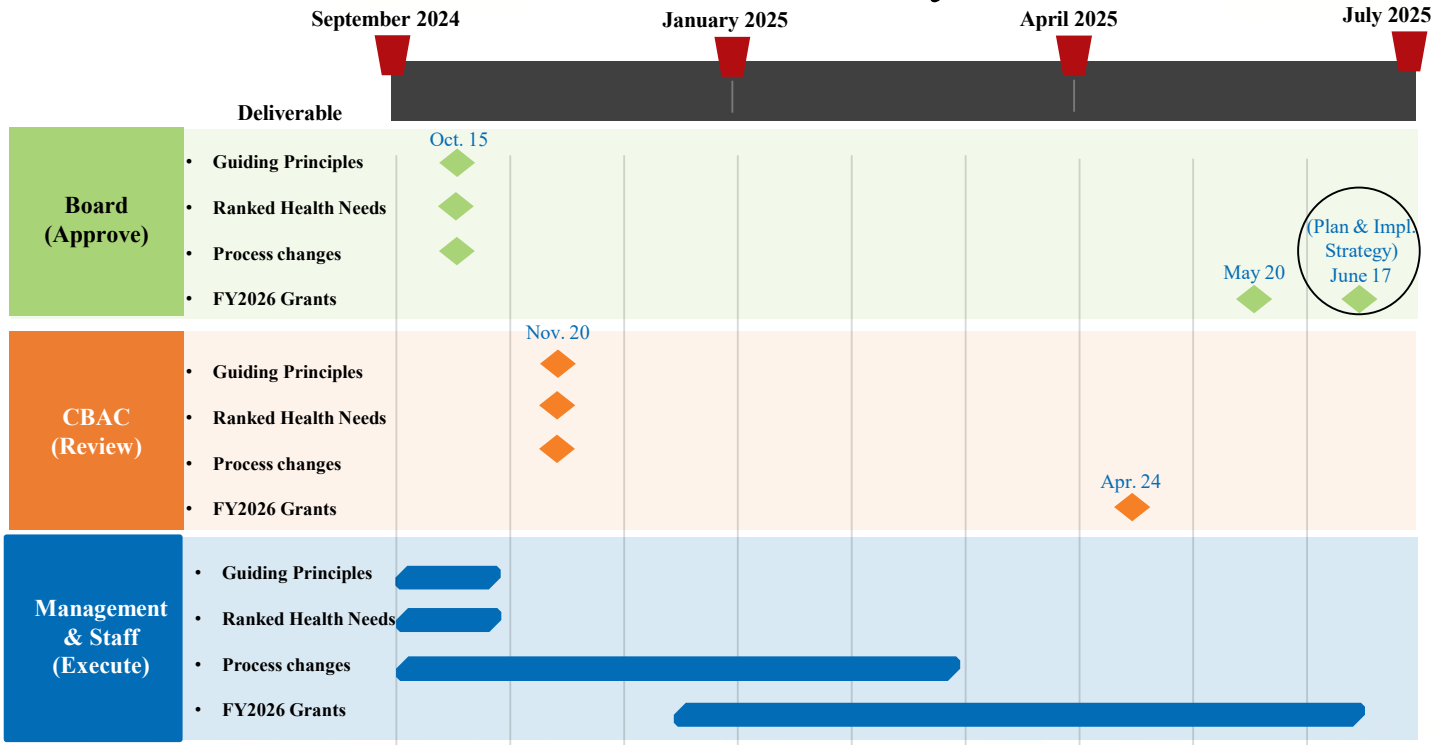
FY2026 ECHD Community Benefit Plan

Jon Cowan, Executive Director,
Government Relations & Community Partnerships
June 17, 2025

Agenda

- Feedback from May Study Session & Action to Address
- Revised FY2026 Community Benefit Plan: Changes & Summary
- Recommendation

Timeline for District Community Benefit



Feedback from May Study Session and Action to Address

Feedback Item	Action
1) Evaluate if opportunity for additional funding for high-performing grantees that can absorb funds. 2) Consider that two-year grants will not have an opportunity to apply for more funds for FY2027.	**Evaluated portfolio and recommend additional funding for the high-performing and impactful Community Service Agency grants. For school nurse grants, identified a need to better understand performance related to follow-up care with health providers which will require additional dialogue during FY2026.**
3) Ensure fiscal responsibility to be able to respond to urgent needs due to expected cuts later in the year that impact vulnerable populations.	**Recommend maintaining sufficient funds in placeholder to serve as an emergency reserve fund for urgent needs that arise later in year.**
4) Propose concrete options for additional use of funds.	**Recommend options to consider for additional use of placeholder reserve funds.**

FY2026 Summary of Proposals Portfolio (updated)

74 **Proposals**

Requested **$10.46M**

7.9% increase

$8.41M **Recommended**

ECHD Grants Grouped by Health Need* (Updated)

*Percentages do not sum to 100% due to rounding. Total approved presented is rounded total.

Health Need	FY2025 Approved	FY2025 %	FY2026 Proposed	FY2026 %
Healthcare Access & Delivery	$4.007 million	51%	$4.226 million	50%
Behavioral Health	$1.852 million	24%	$1.878 million	22%
Diabetes & Obesity	$1.155 million	15%	$1.261 million	15%
Chronic Conditions (other than diabetes & obesity)	$388,000	5%	$474,600	6%
Economic Stability	$437,000	6%	$573,600	7%
Total	**$7.840 million**		**$8.413 million**	

Post-Study Session: Updated Grant Recommendation & Rationale

Staff recommends additional increases after Study Session Feedback of **+$111,000**:

- All grants below are high-performing grants; all are also 2-year grants
- The CSAs have **strong ECHD service concentration**, and are **most able to absorb additional funds**
- Staff weighed balance of deploying additional funds, while ensuring meaningful reserve dollars

Category	Agency	CBAC Rec.	Post-Study Session Rec.	New Amount	Rationale
CSA **All 3 CSA grants now recommended at full requested amount*	CSA of MV, LA, LAH	$284,000	+$42,600	**$326,600**	Community Service Agencies are impacted by Federal Medicaid cuts that will cause people to lose their insurance coverage. This will likely make case management services imperative for maintaining enrollment in Medi-Cal. Additionally, may be impacted by Federal food assistance funding that is at-risk for reductions. The additional funds will help to further support the case management needs and individuals experiencing medical hardship.
	Sunnyvale Community Services - Social Work /Homebound Case Mgmt	$247,700	+$19,200	**$266,900**	
	Sunnyvale Community Services – Safety Net Services	$82,500	+$49,200	**$131,700**	

Summary of FY2026 Plan

- **Total Plan Amount: $9 million**
  - **Grant Program: $8,413,000**
  - **Sponsorships: $90,000**
  - **Placeholder: $497,000***

**Proposed options for use of placeholder:*

§ **Option 1:** All placeholder reserved for emergency funding, and allow grantees (within defined criteria) to request additional funds later in the year

§ **Option 2:** Option 1, but with up to $50,000 for Community College Health Professions stipends

§ **Option 3:** Option 2, but with up to $50,000 for Hospital employee-focused innovation programming

Placeholder Proposed Options - Details

The options below represent three proposed ways to allocate the remaining Placeholder total dollars **($497,000).**

Option	Option Description	Subtotal Amounts	Details & Narrative
Option 1	Reserve for an **opportunity for grantees to request increased funds**	Up to: • **$497,000** – reserved for additional grantee funding	FY2026 grantees that fit high priority grant criteria may request increased funding: • Grant history of high-performance • Impacted by federal funding cuts (depending heavily on Medicaid funding, SNAP and other sources of federal funds) and/or • Addressing health access needs for vulnerable populations **Timeline: Oct-Dec 2025:** Conduct outreach to grantees early Oct; decisions on add'l funds by Dec
Option 2	Option 1, **with** funds for **Community College health profession stipends**	Up to: • **$447,000** grant reserve • **$50,000** Community College Health Professions stipends	Option 1, with up to $50,000 for potential new programming focused on providing community college health professions students with stipends to support and encourage the pursuit of health careers to address the labor shortage in the healthcare workforce. Focus on students interested in working at El Camino Health. • Expand opportunities for students by helping to address economic barriers. • Invest in students to fill roles needed in the local community. • E.g., provide $1000/month (for 10-month school year) to cohort of 5 students
Option 3	Option 2, **with** funds for **hospital-driven innovation programming**	Up to: • **$397,000** grant reserve • **$50,000** Community College Health Professions stipends • **$50,000** Hospital Innovation Programming	Option 2, with up to $50,000 for Innovators Education Series to nurture innovative potential of ECH employees • Train hospital employees on an accessible, step-by-step framework to evaluate and address problems in care. • Programming and educational activities includes a structured, multi-dimensional approach to offer both one-time and longer-term opportunities • Program success based on volume metrics over time as well as cultivating a culture of innovation and learning within the healthcare community.

Recommendation

- **Action Item**: To approve the FY2026 El Camino Healthcare District Implementation Strategy Report and Community Benefit Plan (Community Benefit Plan). To approve authority for Jon Cowan, Executive Director of Government Relations & Community Partnerships, to execute all grant agreements specified in the Plan.

  Approve Community Benefit Plan as is: total $9,000,000 including grants ($8,413,000), sponsorships ($90,000), and placeholder ($497,000)

  or

  Approve Plan with amendments

Board Discussion

Appendix

FY2026 Strategy Highlights

Strategic increases to support high-performing existing programs that can deliver additional services with additional funding, and targeted additional investments to address community health needs in the current climate.

- **Enhancing oral health access and addressing a need in the community** through new funding for Health Mobile to provide comprehensive mobile dental services to low-income families (including pediatric dentistry), seniors, and homeless individuals in Sunnyvale and Mountain View.

- **Supporting more services to support those that are unhoused/at-risk of becoming unhoused and supporting for older adults to remain in their homes** through new funding for Helping Hands Silicon Valley for immediate and flexible support services including emergency hotel stays, transportation assistance to healthcare appointments and access to hygiene essentials and for Rebuilding Together Silicon Valley to provide home repair and accessibility modifications for low-income older adults.

- **Increased funding for clinics providing direct healthcare access who may be facing federal funding pauses or reductions and are serving vulnerable communities** such as Planned Parenthood Mar Monte and Ravenswood.

FY2026 Strategy Highlights (continued)

Two-year grants for the ten ECHD school healthcare, school mental health programs, and community service agencies continue for FY2026-2027.

- Recommend continuing to fund the **school healthcare programs** and to provide increases to the three school districts with consistent two-year grants to account for annual grantee expense increases. This will address a key community need while balancing other impactful investments for healthcare access and delivery in the District.
- Due to program transitions which have impacted performance for the **school mental health programs**, the recommendation is to keep school mental health investments flat and monitor programs to understand community need and right-size program volume established through last term's actual baseline.
- Recommend increases to the **community services agency grants** to enhance support for emerging needs in the current climate for vulnerable populations in the District, as well as reallocating from Second Harvest to direct services models to better ensure consistent nutritious food is available in the community.

FY2026 Strategy Highlights (continued)

Staff Innovation Grants continuing for the Health Care Navigator and Population Health Program Manager to further strengthen collaboration and coordination efforts.

The **Health Care Navigator** in the Care Coordination Department has continued to be successful in connecting patients with services in the local community and in collaboration with partner agencies to obtain essential care to help to prevent hospital re-admissions and further health deterioration.

- By midyear FY2025, the Health Care Navigator has successfully helped connect 250 patients with clinical and/or community services in the local community
- Additionally, Care Coordination has hosted three community convening events in the past 12 months (with a fourth scheduled in May 2025) to connect with grantees and foster collaboration among community agencies

The **Population Health Program Manager** has completed the preliminary research & design for the 3-5 year Population Health Strategy for the initial primary focus area to combat rising risks for prediabetes.

- The program manager also completed a comprehensive review of Population Health activities across El Camino Health Service lines, created a “data inventory” of 70+ data sources to inform current and future population health efforts, and supported the Community Health Needs Assessment and Implementation Strategy Report & Community Benefit Plan.
- *[FY2026 Objectives continued on next slide]*

FY2026 Strategy Highlights (continued)

For FY2026, the **Population Health Program Manager** will focus on:

- **Population Health Strategy:** Further refine strategic roadmap and measurement framework for prediabetes programming; iterate on roadmap throughout FY2026 as needed; report on roadmap progress and updates at regular cadence
- **Prediabetes program management:** Prediabetes vendor implementation, launch, data-driven outreach and program design, lead partner meetings and deliverables
- **Cross-functional measurement & evaluation:** Conduct ongoing monitoring and evaluation of district analytics related to Community Health Needs Assessment (CHNA) and Implementation Strategy (IS), support improvements to CB grant portfolio metrics and evaluation methodologies
- **Social Determinants of Health (SDoH) and Quality reporting:** Support research and analytics at the intersection of Quality reporting, SDoH, care coordination, and population health with the Mountain View hospital
- **Data infrastructure and analytic tools:** Continue to collaborate with partners on population health measurement (e.g. Silicon Valley Index with Joint Venture Silicon Valley), conduct ongoing evaluation of population health reporting tools (e.g. Epic's Healthy Planet, Epic's Compass Rose, Vizient and Sg2), investigate data sharing and interoperability with partner organizations

Recommend continuing two-year grants for FY2026-2027

Two-year grants for key programs and proven partners with a long history of success ensured stability to adequately plan programs, staffing and funding. Additionally, it streamlined the application process and alleviated administrative burden to focus on program efforts.

- **For School Healthcare and Community Services Agencies (CSA) grants, the recommendation is to continue two-year grants with strategic increases** to the CSA Case Management and Safety-Net Services to enhance support for emerging needs in the current climate and vulnerable populations in the District and also to provide an increase to the three school districts with consistent two-year grants to address community needs while balancing other impactful investments for healthcare access and delivery in the District.

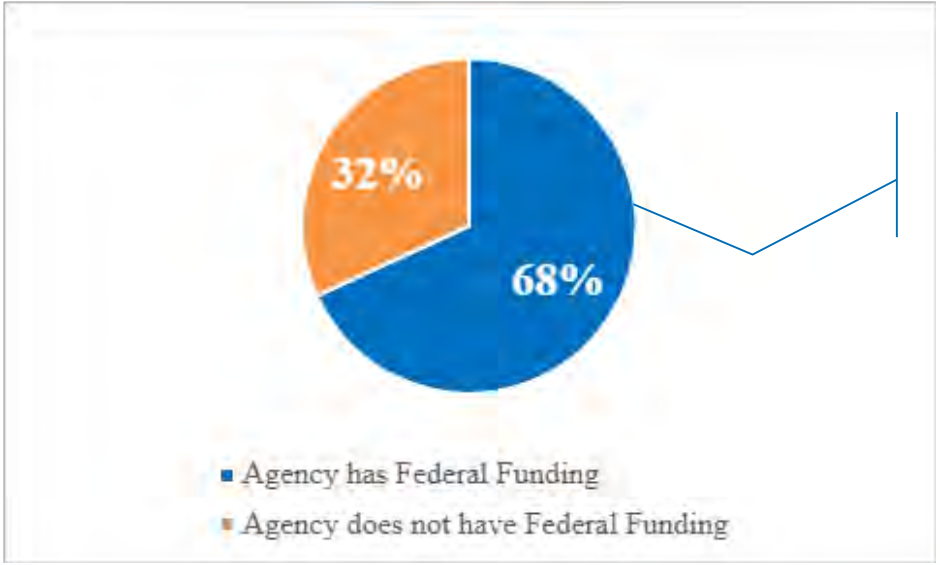
- Due to the transitions which have impacted performance **for the School Mental Health grants, the recommendation is to keep investments flat and monitor programs** to understand community need and right-size program volume established through last term's actual baseline.

Impact of Federal Funding Pauses and Reductions

	Item	Update
What we heard	Preliminary findings and recommendations	Agencies surfaced how the federal funding changes could affect programs staffing, achieving program metrics and organization impacts and general community needs. FY2026 funding recommendations are informed by site visit findings related to needs due to federal funding pauses or reductions.
What we did / will do	Conducting continuous monitoring of emergent needs related to changing federal funding status	Community Partnerships has been engaged with agencies on the effects of federal funding changes through reviewing program reporting, site visits and implementing a survey regarding impacts of federal funding pauses or reductions.

Impact of Federal Funding Pauses and Reductions – Survey Results

Over two-thirds of FY2025 ECHD grant partner respondents have current federal funding as part of their organizational budget.



Of those who receive federal funding, 75% are anticipating reductions.

FY2025 Site Visits

Site Visits with all 59 grant partners – 100% participation

- 26 Site Visits
- 4 ECHD Board Meeting Site Visits
- 6 Group Site Visits conducted virtually (average 5 grants per group – total 29 grants)

Emerging community needs surfaced during site visits:

- Grantees see dental services needs for children, people at risk of homelessness and veterans.
- School healthcare programs continue to see vaccination needs and programs impacted by transitional kindergarten grade level added before kindergarten.
- Eyeglass resources are in demand for school healthcare programs.
- Grantees find that the digital divide and digital safety impacts age groups in a variety of ways.
- Grantees serving the senior population see growing demand for paratransit door-to-door services.
- Potential impacts of federal funding pauses/terminations with current administration and impact of fear for those who are undocumented accessing services.

FY2025 Site Visits (continued)

Some of the site visit findings helped to inform the funding recommendations.

Site Visit Takeaways	Funding Recommendations
Dental services needs for children, people at risk of homelessness, veterans	New funding for Health Mobile in the District to provide comprehensive mobile dental services to low-income families (including pediatric dentistry), seniors, and homeless individuals in Sunnyvale and Mountain View helping to support a high need in the community. This grant will add a service site to the District.
School healthcare programs impacted by transitional kindergarten added grade level for 4-year-olds and vaccinations needs	Recommend increases to the three school districts with consistent two-year grants to account for annual grantee expense increases. This will address a key community need while balancing other impactful investments for healthcare access and delivery in the District.
Lack of available nutritious food distributions to adequately stock District food pantries	Direct funding for CSA food pantries to make nutritious food purchases for foods not available through current Second Harvest food distributions to ensure nutritious food is available to the community.
Potential impacts of federal funding pauses/terminations with current administration for vulnerable populations	Increased funding for clinics providing direct healthcare access who may be facing federal funding pauses or reductions such as Planned Parenthood Mar Monte and Ravenswood who are serving vulnerable communities.

CBAC Feedback

- Population health convening: consider using the FY2026 bi-annual (once every two years) grantee convening (as defined on the ECHD Strategic Framework) as an opportunity to link Diabetes & Obesity health need partners to our District prediabetes work.
- For population health prediabetes work, further include and engage the community in program design, and consider the importance of building awareness before people will change behavior.
- For next cycle, explore what the data says about the needs of the college-age/young-adult (16-25 year old) population, and consider behavioral health programming for this cohort. If there's a need identified for this age group, make efforts to generate a grant application which aligns with addressing this need.
- Surfaced that funding Roots Community Center can help to address the diabetes and obesity health need for the African American Community which is disproportionally impacted and is not currently funded in the grant portfolio.
- For FY2026 October Program Guidance, recommended that the Community Benefit program could consider updating the policy guidance to increase the two-year funding threshold to 50% of the annual grant total.

Guiding Principles for Evaluating and Prioritizing Appropriateness of Grant Proposals

Required

1. Serve those who live, work or go to school in El Camino Healthcare District's targeted geography
2. Demonstrate a competence and capacity to address at least one of the identified health needs
3. Focus primarily, but not exclusively, on the results of increasing access to healthcare services, behavioral health services, as well as the management of rising risk chronic health conditions (diabetes, obesity, cardiovascular disease, cancer, and respiratory conditions)
4. Have an emphasis on populations that are underserved, experiencing health disparities, and/or facing health challenges

Preferred

5. Aim to reflect the diversity of El Camino Healthcare District's targeted geography
6. Focus on operational programmatic costs for service delivery, over capital campaigns
7. Emphasize locally focused vs. national organizations
8. Emphasize the most effective and impactful programs while welcoming new and innovative applicants

ECHD Ranked & Prioritized Health Needs

Health Need	FY2024 Approved	FY2025 Approved	FY2026 Approved
Healthcare Access & Delivery (including oral health)	51%	51%	~50%
Behavioral Health (including domestic violence & trauma)	24%	24%	~25%
Diabetes & Obesity	15%	15%	~15%
Chronic Conditions (other than diabetes & obesity)	5%	5%	~5%
Economic Stability (including food insecurity, housing & homelessness)	5%	6%	~5%

Proposal Evaluation Process

Top three factors that are referenced during the grant evaluation process

Approved percentages for each health need → Guiding Principles → Evaluation Criteria (next slide)

Proposal Evaluation Process (continued)

Proposal evaluation criteria:

- Alignment with ECHD priorities
- Addressing community needs
- Applicant capability
- Proposal quality
- Impact and evaluation plan
- Budget request
- Evidence-based programming
- Financial need of applicant
- Brand alignment (i.e. will not reflect negatively on reputation, brand)

Proposals were also evaluated in context of those in each health need, then grouped by their proximity to the median for review in the grant index.

FY2026 Applications for New Programs

Recommended for funding-4	Not recommended for funding-14	
• Health Mobile • Helping Hands Silicon Valley • Rebuilding Together Silicon Valley • Roots Community Health Center	• AbilityPath • Counseling and Support Services for Youth • Downtown Streets Team • Fremont Union High School District • Lotus Family Services • MedCycle Network • Positive Alternative Recreation Teambuilding Impact • Project Safety Net Inc. • Rebuilding Together Peninsula • Red-White and Blue Charity	• Stanford Health Care - Trauma Injury Prevention Program Administration • Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL) • Vista Center for the Blind and Visually Impaired • Youth Community Services

FY2025 grantee: Second Harvest of Silicon Valley – For FY2026 funds reallocated to Sunnyvale Community Services and Community Services Agency of Mountain View-Los Altos for direct purchase of nutritious foods.

FY2026 Grant Applications: Not Recommended for Funding

In addition to key factors such as approved percentage allocations by health need and guiding principles, some other recurring themes arose for reasons why new applicants were not recommended for funding:

1. Lack of alignment with the Implementation Strategy and selected health needs
2. Lack of clarity on how the proposed program will impact health outcomes for targeted populations
3. Budget not aligned with stated goals, not clear on proposed use of funds, or requested amount is not reasonable
4. Service limited to a low number of people and high cost per person/service

FY2026 New Grant Applicants – 18 total

Fund/ DNF	Agency	Program Description
DNF	AbilityPath	Adult Day Program serves adult individuals with intellectual or developmental disabilities. This grant would fund the Pathways to Health and Wellness curriculum promoting healthy living routines and practices through nutrition & fitness education and activities focused on building an individuals overall physical and emotional well-being. Programming is focused on wellness classes, fitness/exercise classes, and education and learning.
DNF	Counseling and Support Services for Youth	MFT and MSW therapists provide school-based mental health services to students through individual/group therapy, check-ins, and psychosocial education, along with family/staff consultations and support for schools in the Mountain View Los Altos School District and Mountain View students at two private schools: Khan Lab Schools.
DNF	Downtown Streets Team	Case Manager provides case management and employment services and workshops for clients actively experiencing homelessness or at-risk of homelessness in Sunnyvale.
DNF	Fremont Union High School District	Wellness space support specialist at Homestead High School determines the presenting need of the student, supports wellness activities and facilitates a referral to a school-based therapist, as appropriate. The long-term impact of a wellness space is a reduction in the need for intensive care through a coordinated program that provides early intervention, activities, and individual and group counseling.

FY2026 New Grant Applicants – 18 total (continued)

Fund/ DNF	Agency	Program Description
Fund	Health Mobile	Dentist and clinic staff provide comprehensive mobile dental services to low-income families (including pediatric dentistry), seniors, and homeless individuals in Sunnyvale and Mountain View.
Fund	Helping Hands Silicon Valley	Volunteers will provide immediate and flexible support services to unhoused or those at-risk of becoming unhoused, such as emergency motel stays during inclement weather or medical emergencies, transportation assistance to healthcare appointments, and access to essential resources like food and clothing.
DNF	Lotus Family Services	Licensed and Associate therapists/social workers provide psychoeducational group training sessions, individual parent coaching and parent-child group retreat to identified at-risk youth and their families.
DNF	MedCycle Network	MedCycle personnel pick up surplus medical supplies and equipment from El Camino Health Mountain View, inventory, store and then deliver these supplies and equipment to local safety-net clinics that serve individuals who are uninsured or underinsured.
DNF	Positive Alternative Recreation Teambuilding Impact	Program Coordinators, College mentors, and youth interns work with low-income youth on social-emotional development and behavioral skills to empower them in developing essential life skills.

FY2026 New Grant Applicants – 18 total (continued)

Fund/ DNF	Agency	Program Description
DNF	Project Safety Net Inc.	The Convening Community for Youth Mental Health Promotion and Suicide Prevention program convenes community members, organizations, and public agencies in the areas of youth mental health, well-being, and suicide prevention to build relationships and share information about resources. This grant would fund outreach and community meetings in the Mountain View, Los Altos and Sunnyvale.
DNF	Rebuilding Together Peninsula	Rebuilding Together Peninsula staff along with some subcontractors provide necessary home repairs for low-income seniors many of which have disabilities.
Fund	Rebuilding Together Silicon Valley	Construction Services Program Manager, Repair Technician, Program Director, and Client Services Coordinator to provide home repair and accessibility modifications for low-income older adults in Sunnyvale.
DNF	Red-White and Blue Charity	Rebuilding Together Peninsula staff along with some subcontractors provide necessary home repairs for low-income seniors many of which have disabilities.
Fund	Roots Community Health Center	Clinical staff provide diabetes and obesity screening, education, and awareness activities to the African American community and other people of color in Sunnyvale and Mountain View.

FY2026 New Grant Applicants – 18 total (continued)

Fund/ DNF	Agency	Program Description
DNF	Stanford Health Care - Trauma Injury Prevention Program Administration	Occupational Therapist and Injury Prevention/Project Coordinator work with eligible low-income seniors to educate them on exercise, nutrition and creating safe walking routes within their community.
DNF	Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL)	LMFT provides evidence-based health and wellness services that address emotional and mental well being for low-income youth.
DNF	Vista Center for the Blind and Visually Impaired	Social worker, assistive technology specialists, orientation and mobility, adaptive living instructors, guidance counselor, patient care coordinators, and an optometrist provide services promoting self-sufficiency for low-income individuals who are blind or visually impaired located at agency site and virtually.
DNF	Youth Community Services	Youth Community Service staff will seek to enhance low-income youth awareness of community issues while promoting behavioral and mental health development through a two-part program at Mountain View Los Altos High School.

FY2026 Recommended Dual Funded Programs Summary

Health Need	Agency	Requested	CBAC Recommended
Diabetes & Obesity	Bay Area Women's Sports Initiative	$84,716	$39,000
Diabetes & Obesity	Chinese Health Initiative	$290,000	$275,000
Healthcare Access & Delivery	Cupertino Union School District	$110,000	$110,000
Behavioral Health	Cupertino Union School District	$112,000	$102,500
Healthcare Access & Delivery	Health Mobile	$150,000	$50,000
Healthcare Access & Delivery	LifeMoves	$160,000	$160,000
Behavioral Health	Momentum for Health	$290,000	$290,000
Diabetes & Obesity	Playworks, Northern California	$228,819	$228,800
Diabetes & Obesity	South Asian Heart Center	$330,000	$310,000

Proposals by Health Need: **Healthcare Access and Delivery**

Proposal Strength: Higher	• Mountain View Whisman School District • On-Site Dental Care Foundation • Pathways Home Health and Hospice • Peninsula Healthcare Connection	• Planned Parenthood Mar Monte • Ravenswood Family Health Network (MayView Clinics) • Sunnyvale School District
Proposal Strength: Medium	• AnewVista Community Services • Cupertino Union School District • El Camino Health - MV RoadRunners • El Camino Health - Population Health • El Camino Health - Care Navigation	• Lucile Packard Foundation for Children's Health • Santa Clara Valley Healthcare, County of Santa Clara
Proposal Strength: Lower	• El Camino Health - Health Library • Health Mobile • LifeMoves	• MedCycle Network • Vista Center for the Blind and Visually Impaired

Proposals by Health Need: **Behavioral Health**

Proposal Strength: Higher	• Avenidas • Caminar - Domestic Violence Program • Caminar - LGBTQ Speaker Bureau Program • Eating Disorders Resource Center • Kara	• Law Foundation of Silicon Valley • Maitri • Momentum for Health • National Alliance on Mental Illness - Santa Clara County • Pacific Clinics
Proposal Strength: Medium	• Acknowledge Alliance • Counseling and Support Services for Youth • Cupertino Union School District • Fremont Union High School District • Friends For Youth • Health Connected (formerly My Digital TAT2)	• Lighthouse of Hope Counseling Center • Los Altos School District • Mountain View-Los Altos Union High School District • YWCA Golden Gate Silicon Valley
Proposal Strength: Lower	• Friendly Voices - Phone Buddies for Seniors • Lotus Family Services • Positive Alternative Recreation Teambuilding Impact	• Project Safety Net Inc. • Red-White and Blue Charity • Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL) • Youth Community Service (YCS)

Proposals by Health Need: **Diabetes & Obesity**

Proposal Strength: Higher	• Chinese Health Initiative (CHI) • City of Sunnyvale - Columbia Neighborhood Center • Living Classroom • Playworks, Northern California • YMCA of Silicon Valley
Proposal Strength: Medium	• American Diabetes Association • Bay Area Women's Sports Initiative - Girls Program • Fresh Approach • Silicon Valley Bicycle Coalition • South Asian Heart Center (SAHC)
Proposal Strength: Lower	• AbilityPath • Bay Area Women's Sports Initiative - Rollers Program • Roots Community Health

Proposals by Health Need: **Chronic Conditions**

Proposal Strength: Higher	• Breathe California of the Bay Area, Golden Gate and Central Coast • Community Services Agency of Mountain View, Los Altos, and Los Altos Hills
Proposal Strength: Medium	• American Heart Association
Proposal Strength: Lower	• Stanford Health Care - Trauma Injury Prevention Program Administration

Proposals by Health Need: **Economic Stability**

Proposal Strength: Higher	• Day Worker Center of Mountain View • Hope's Corner Inc • Mountain View Police Department • Sunnyvale Community Services - Social Work/Homebound Case Management • Sunnyvale Community Services - Comprehensive Safety Net Services
Proposal Strength: Medium	• Rebuilding Together Silicon Valley • Second Harvest of Silicon Valley • The United Effort Organization, Inc.
Proposal Strength: Lower	• Downtown Streets Team, Inc. • Helping Hands Silicon Valley • Rebuilding Together Peninsula

ECHD Grant Application Geographical Data

All Grant Proposals	Cupertino	Los Altos	Los Altos Hills	Mountain View	Sunnyvale	Total
Recommended Funds	$498,296 (6%)	$614,643 (7%)	$170,760 (2%)	$3,583,798 (43%)	$3,440,003 (41%)	$8,302,000 (100%)
Recommended People Served	3,150 (5%)	3,713 (5%)	3,530 (5%)	29,742 (44%)	28,131 (41%)	68,266 (100%)
Recommended Services Provided	7,333 (4%)	11,084 (7%)	4,774 (3%)	81,817 (49%)	63,459 (38%)	168,467 (100%)

ECHD Grant Application Geographical Data

CSA Grant Proposals	Cupertino	Los Altos	Los Altos Hills	Mountain View	Sunnyvale	Total
Recommended Funds	$0 (0%)	$11,360 (2%)	$5,680 (1%)	$264,120 (43%)	$333,040 (54%)	$614,200 (100%)
Recommended People Served	0 (0%)	4 (0%)	2 (0%)	89 (11%)	715 (88%)	810 (100%)
Recommended Services Provided	0 (0%)	195 (1%)	97 (1%)	4,528 (32%)	9,525 (66%)	14,345 (100%)

School Grant Proposals	Cupertino	Los Altos	Los Altos Hills	Mountain View	Sunnyvale	Total
Recommended Funds	$0 (0%)	$199,500 (13%)	$23,000 (1%)	$505,500 (32%)	$838,900 (54%)	$1,566,900 (100%)
Recommended People Served	0 (0%)	334 (5%)	20 (0%)	2,948 (45%)	3,314 (50%)	6,616 (100%)
Recommended Services Provided	0 (0%)	1,194 (7%)	86 (1%)	7,820 (48%)	7,170 (44%)	16,270 (100%)

El Camino Health and El Camino Healthcare District Dual-Funded Community Benefit Programs: FY2024, FY2025 & FY2026

El Camino Health FY2024: $555,000 (17% of ECH grants)*| FY2025: $560,000 (17% of ECH grants)*
FY2026 (Recommended): $565,000 *(17% of ECH grants)*

El Camino Healthcare District FY2024: $1,696,500 (22% of ECHD grants)*| FY2025: $1,585,500 (20% of ECHD grants)*
FY2026 (Recommended): $1,674,000 *(20% of ECHD grants)*

Combined Total FY2024: $2,251,500 (20% of all grants)*| FY2025: $2,115,500 (19% of all grants)*
FY2026 (Recommended): $2,239,000 *(19% of all grants)*

**FY2024 & FY2025 dual request totals reflect accurate totals, only programs that are also a dual request for FY2026 are presented below.*

Bay Area Women's Sports Initiative Program (BAWSI)
FY2024 – $41,000 (BAWSI Girls)
ECH - $15,000
ECHD -$26,000
FY2025 – $59,000
ECH - $20,000
ECHD -$39,000
FY2026 – $59,000 (BAWSI Girls - Recommended)
ECH - $20,000
ECHD -$39,000
(BAWSI Rollers - Not a Dual Applicant)

Caminar
FY2026 – $78,700 (Recommended)
ECH – DNF
ECHD -$78,700

Chinese Health Initiative (ECH)
FY2024 – $295,000
ECH - $20,000
ECHD -$275,000
FY2025 – $305,000
ECH - $30,000
ECHD -$275,000
FY2026 – $305,000 (Recommended)
ECH - $30,000
ECHD -$275,000

Cupertino Union School District – Mental Health Counseling
FY2024 – $232,500
ECH - $130,000
ECHD -$102,500
FY2025 – $232,500
ECH - $130,000
ECHD -$102,500
FY2026 – $232,500 (Recommended)
ECH - $130,000
ECHD -$102,500

Cupertino Union School District – School Nurse Program
FY2024 – $215,000
ECH - $110,000
ECHD -$105,000
FY2025 – $215,000
ECH - $110,000
ECHD -$105,000
FY2026 – $220,000 (Recommended)
ECH - $110,000
ECHD -$110,000

Downtown Streets Team
FY2026 – DNF (Recommended)
ECH – DNF
ECHD – DNF

Health Mobile
FY2026 – $110,000 (Recommended)
ECH – $60,000
ECHD - $50,000

LifeMoves
FY2024 - $210,000
ECH - $50,000
ECHD - $160,000
FY2025 – $210,000
ECH - $50,000
ECHD -$160,000
FY2026 – $210,000 (Recommended)
ECH - $50,000
ECHD -$160,000

Medcycle
FY2023 – DNF
ECH - DNF
ECHD - DNF

Momentum for Mental Health
FY2024 – $330,000
ECH - $40,000
ECHD - $290,000
FY2025 – $330,000
ECH - $40,000
ECHD -$290,000
FY2026 – $330,000 (Recommended)
ECH - $40,000
ECHD -$290,000

Playworks
FY2024 – $240,000
ECH - $40,000
ECHD -$200,000
FY2025 – $240,000 (Recommended)
ECH - $40,000
ECHD -$200,000
FY2026 – $268,800
ECH - $40,000
ECHD -$228,800

Rebuilding Together Silicon Valley
FY2026 – $30,000 (Recommended)
ECH - DNF
ECHD -$30,000

South Asian Heart Center
FY2024 – $360,000
ECH - $50,000
ECHD -$310,000
FY2025 – $370,000
ECH - $60,000
ECHD -$310,000
FY2026 – $370,000 (Recommended)
ECH - $60,000
ECHD -$310,000

Vista Center for the Blind and Visually Impaired
FY2026 – $25,000 (Recommended)
ECH - $25,000
ECHD - DNF

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Jon Cowan, Executive Director, Government Relations and Community Partnerships
Date: June 17, 2025
Subject: ECHD Population Health Strategy Update

Purpose: To review the ECHD Population Health Profile as well as the Population Health Strategy Roadmap and provide feedback to management and staff.

Summary:

1. Situation: In FY2024, the District Board adopted a Strategic Framework which included the creation of a Population Health Program Manager position as well as the development of an ECHD Population Health Strategy to develop a foundation for identifying and intervening to improve health of "rising risk" patients who live, work, or go to school within the District. The Population Health Program Manager position was filled in FY2024, and throughout FY2025, in service to these strategic priorities, staff has been focused on District population data analysis, creating a Population Health profile to inform strategic decisions, and developing a Strategy Roadmap to move the project forward to execution and delivery steps. This is an opportunity to review the Population Health Profile and Strategy Roadmap and provide management and staff with feedback.

2. Authority: The Board will review and provide feedback on the Population Health Profile and Population Health Strategy Roadmap.

3. Background: Staff has developed a strategic approach to support future Population Health initiatives. Two key components of this work are **(1) ECHD Population Health Profile**, and **(2) Population Health 3-5 Year Strategy Roadmap**.

(1) ECHD Population Health Profile

a. The Population Health Program Manager has conducted extensive data analysis on the District population to develop a Population Health Profile and to inform strategic direction of Population Health efforts.
b. The profile supports beginning with Prediabetes as a condition area due to it being the highest prevalence chronic condition for adults in the District (45% or ~100,000 adults) as well as being sub-clinical, meaning we can intervene earlier and address individuals before being in a full clinical protocol.
c. Additionally, the population health profile includes further population data that can help to inform execution strategy for targeted outreach & future programming. Data presented in the final profile include:
    i. Age
    ii. Race / ethnicity
    iii. Income
    iv. Insurance Coverage
    v. Proximity to food sources (e.g. grocery stores, farmers markets)
d. Key takeaways on Target Areas and Addressable Market for the Population Health program include:

i. Targeting adults with a combination of digital programming, both individual self-management, and group programming, in addition to separate targeted youth-focused curricula.
ii. The majority of ECHD residents are on commercial insurance but not necessarily low-income
iii. ECHD profile as well as market trends support food/nutrition-focused programming as a good starting point for intervention and programming

(2) Population Health 3-5 Year Strategic Roadmap

a. The 3-5 year strategy proposes three distinct workstreams
   i. **Workstream 1:** Individual self-management program for adults
   ii. **Workstream 2:** Group/social programming to enhance peer support effects
   iii. **Workstream 3:** Education-centric approach to encourage healthy habits in children and adolescents
b. **Timing:** The Roadmap kicks off workstreams in a phased approach, with Workstream 1 moving into Delivery phase in early FY2026, while Workstream 2 and 3 are in a Planning phase first before moving to Delivery later in FY2026 and FY2027
c. **Measurement:** Each Workstream will have a clear set of KPIs and measures of success, which will be defined as follows:
   i. **Year 1:** Baseline year to define success, and scope KPIs / measurement criteria
   ii. **Year 2 & 3:** Two year measurement and evaluation period
   iii. **End of Year 3:** Decision point to continue or transition program
   iv. **Year 4 and beyond:** Continue program (or transition) based on End of Year 3 evaluation
d. **Outreach & Enrollment:** Across all workstreams, outreach and enrollment approach will require creative approach through combination of:
   i. Digital & print outreach campaigns
   ii. In-person events & tabling
   iii. Partnerships with local municipalities, employers, and/or schools.

Reporting to ECHD Board: Staff will provide updates to the ECHD Board twice per fiscal year (March and October). Content of the semi-annual updates will include: (1) program status update, (2) performance dashboard on quantitative and qualitative metrics after Year 1 – baseline year, (3) anticipated next steps.

4. Other Reviews: On May 12, 2025, staff presented Population Health profile and strategy content to Population Health Steering Committee for review and feedback.

5. Outcomes: Staff will incorporate board feedback and proceed to execute on the elements presented in the ECHD Population Health 3-5 year Strategic Roadmap.

List of Attachments:

1. ECHD Population Health Strategy Update.pptx

ECHD Population Health Strategy Update
June 17, 2025

Suggested Board Discussion Questions:

1. Are there any additional factors that should be considered in the Roadmap for the Population Health Strategy?
2. What aspects of the Population Health strategy and prediabetes program design have we not considered?
3. What additional aspects of the Population Health measurement approach should be considered for FY2026 and beyond?
4. What would you like to see from a reporting standpoint approximately every six months?

ECHD Population Health Strategy

Dan Woods, Chief Executive Officer
Jon Cowan, Executive Director, Government Relations & Community Partnerships

June 17, 2025

Agenda

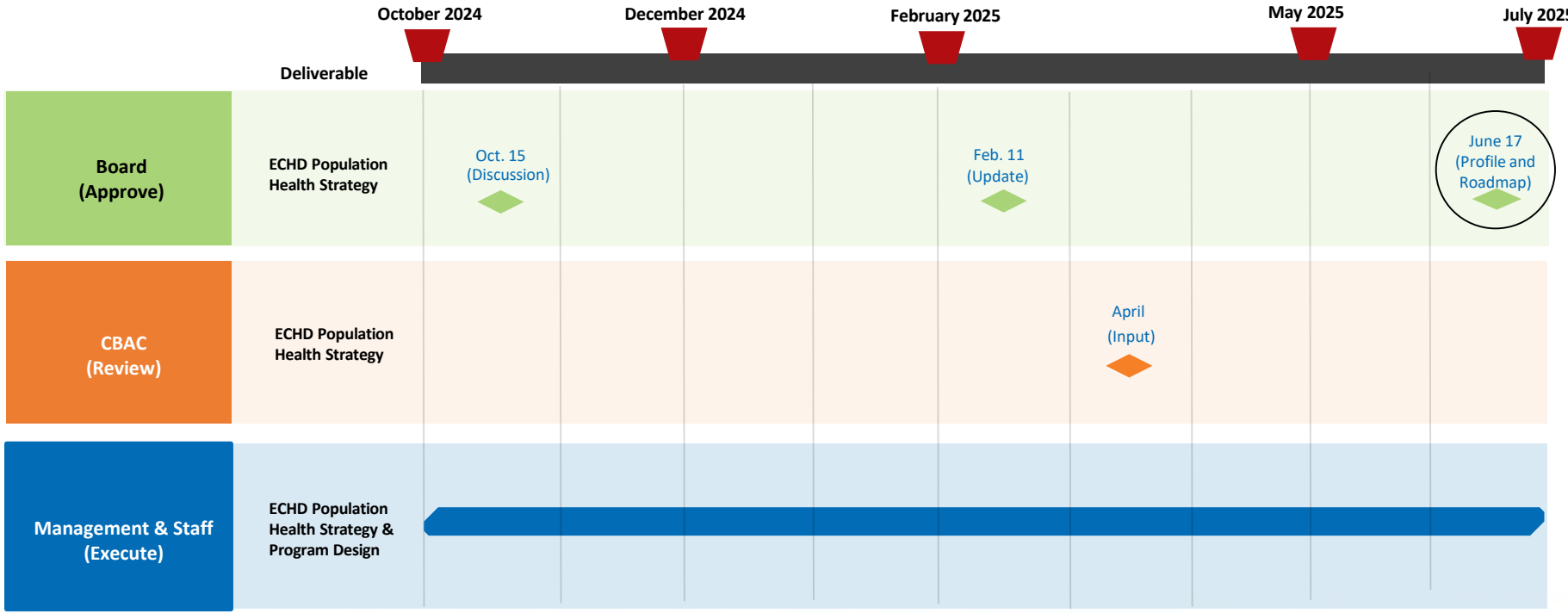
Population Health Strategy & Prediabetes Program Design Update

- Flows from ECHD Board Approved Strategic Framework
- Develop foundation for identifying and intervening to improve health of "rising risk" patients who live, work, or go to school within the district
- Aspiration of being "healthiest healthcare district in America"

Today's Purpose

- ECHD Population Health Profile
- 3-5 Year Population Health Strategy Roadmap
- Prediabetes Programming Measurement Framework

Timeline for Determining ECHD Population Health Strategy



Population Health Overview

What

"Population health can be conceptualized as the **holistic assessment and enhancement of an entire community's or population's overall health outcomes and well-being**, transcending the focus on individual sickness or specific risk factors that dominate health care."
[Reference]

"The goal is to **intervene before acute care is needed.**"
[Reference]

Why

- **Stewardship:** Responsibility to support the health of individuals who live, work, or go to school in ECHD.
- **Strive for excellence:** Ambitious goal of being the "Healthiest Healthcare District in America"
- **Prioritize holistic health:** Focus on prevention, Return on Health, and enhanced quality of life.
- **Lay a foundation:** Building blocks for the future of healthcare, VBC, and long-term ROI for the population

How

[Reference]

Who

- 222,000 adults and 54,000 youth in ECHD
- Top chronic conditions in ECHD adults* :
  - Prediabetes (45%)
  - High Cholesterol (31.2%)
  - High Blood Pressure (21.8%)
  - Obesity (20.1%)
  - Any disability (19.3%)

** Strategy will focus on adults initially, and youth in later stages*

Population Health – Strategic Approach

Mission / Goal:	To make the El Camino Healthcare District the "healthiest healthcare district in America" using an innovative approach that leverages technology to drive reach and outcomes.
Long-term Vision (5-10 years)	Offer a comprehensive suite of programs and wraparound services to support ECHD constituents in preventing and managing an array of chronic diseases.
Near-term Vision (3-5 years)	Develop programs and wraparound services focused to support ECHD constituents with **Prediabetes** management

Why Prediabetes?

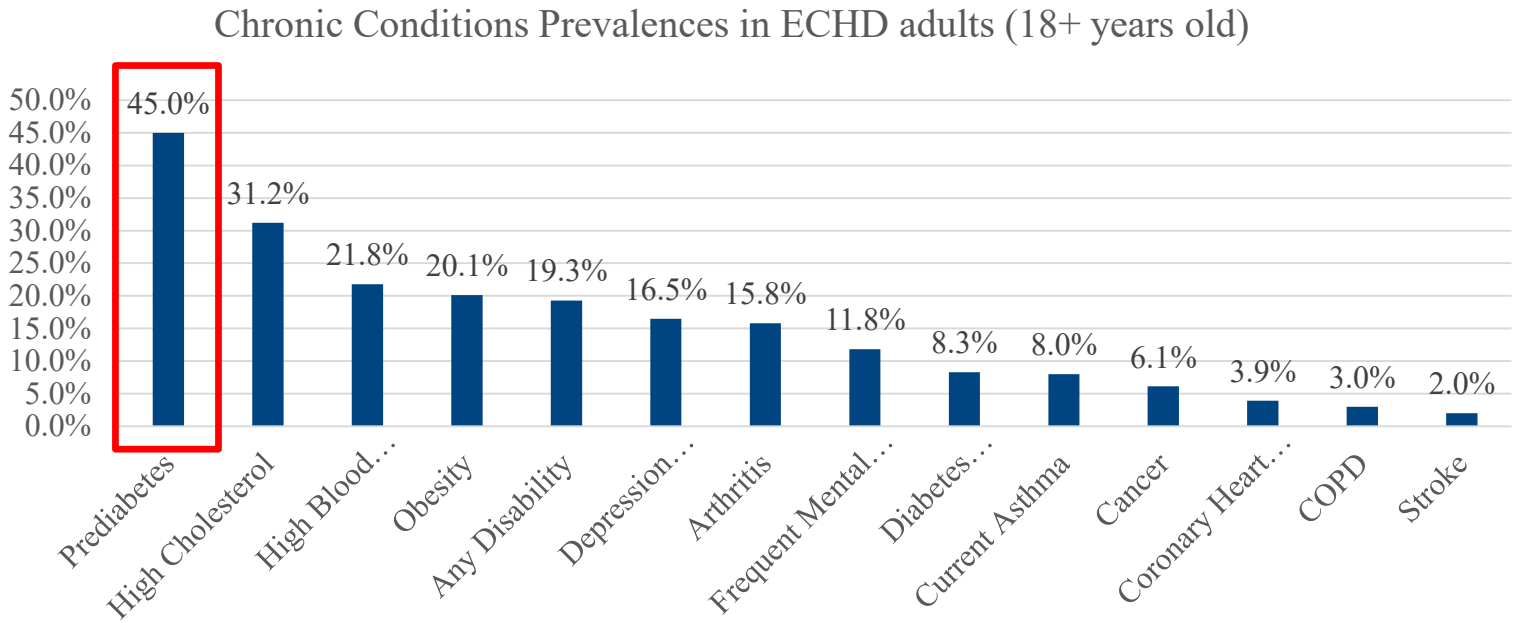
- As a starting point, we used a Population Health approach to identify areas of rising risk and need within our population.
- Data show **Prediabetes** as the highest prevalence chronic condition for adults within the District (45%, or N~100,000, adults). Youth are also heavily affected (26%, or N~14,000).
- Further, Prediabetes is "sub-clinical" meaning we can focus on a broader population and do not need to choose a solution that relies on clinical referral pathways, medication management, etc.

Prediabetes Intervention Context

Opportunity	Considerations and Challenges	Call to Action
• Prediabetes is **manageable and reversible**, through diet/nutrition and physical activity, sleep and other lifestyle and behavioral factors. • Lifestyle and behavioral **interventions can be subclinical**, allowing for real community impact without involved physician oversight or medication management.	• The **lifestyle and behavioral factors** that modify risk are **notoriously difficult to change**. • Standalone Diabetes Prevention Programs (DPPs), and either in-person or digital (mHealth) solutions addressing behavioral changes and lifestyle factors, often see **low enrollment and engagement**, sometimes in the single percentage points.	• A large portion of the population is affected by prediabetes (**45%, or N~100,000 of ECHD adults**, and 26%, or N~14,000 of ECHD youth). • **Over 8 in 10 US adults aren't aware** they have the condition. ECHD can raise awareness of prediabetes. • **ECHD can lead as a convener** and have greater impact by enhancing collaborations with partners, employers, schools, and churches to **collectively tackle the issue**. We seek to **catalyze change in the geography**. • This work represents direct investment back into the community and strong **stewardship of tax dollars** creating **return on health**.

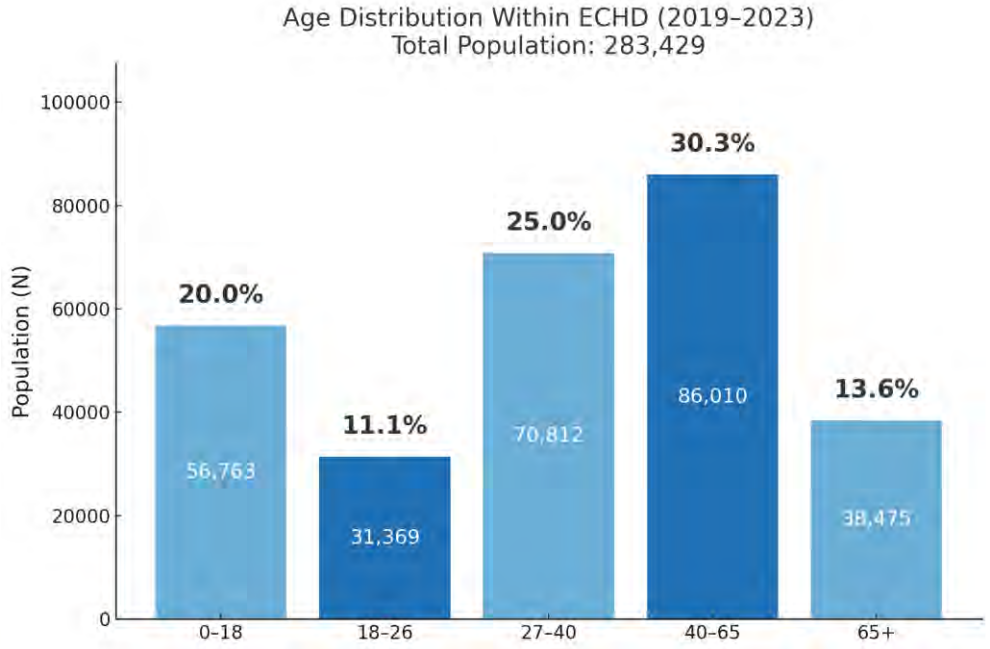
Population Health Profile

Prediabetes is the top chronic condition in ECHD adults



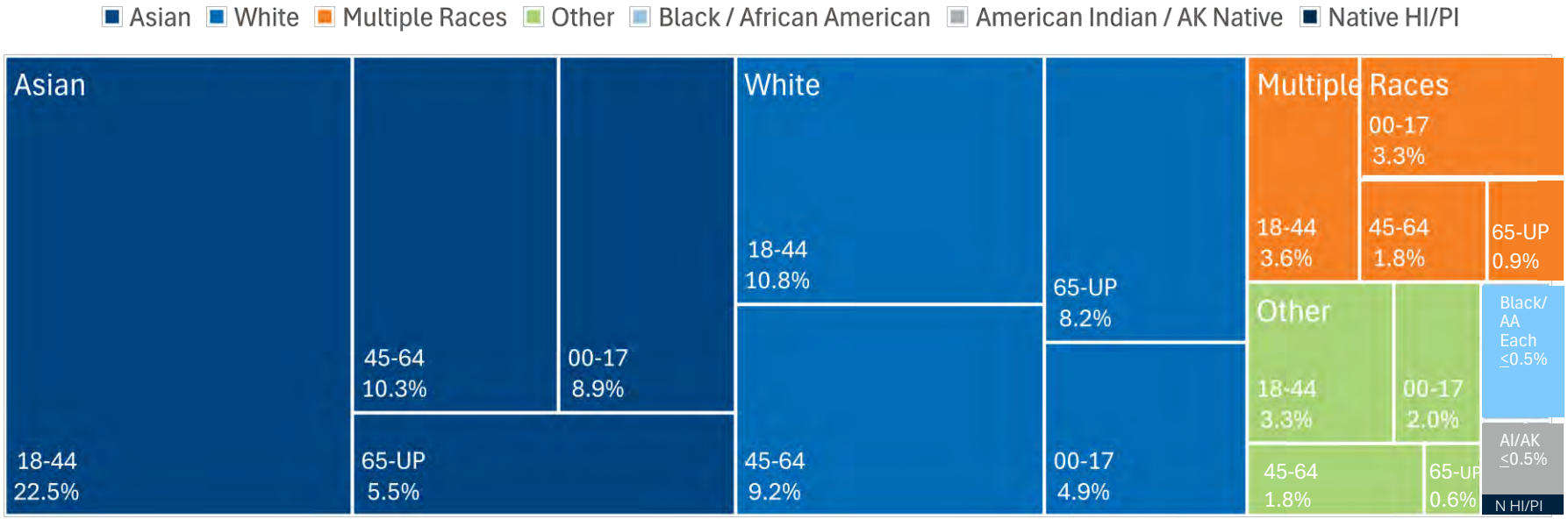
Ref: CDC's BRFSS data on the PLACES website; data for adults aged 18+, from zip codes overlapping with the ECHD; data from 2022, published in 2024

Age groups within ECHD



Ref: U.S. Census Bureau - American Community Survey (ACS) 5-year estimates (2019-2023)

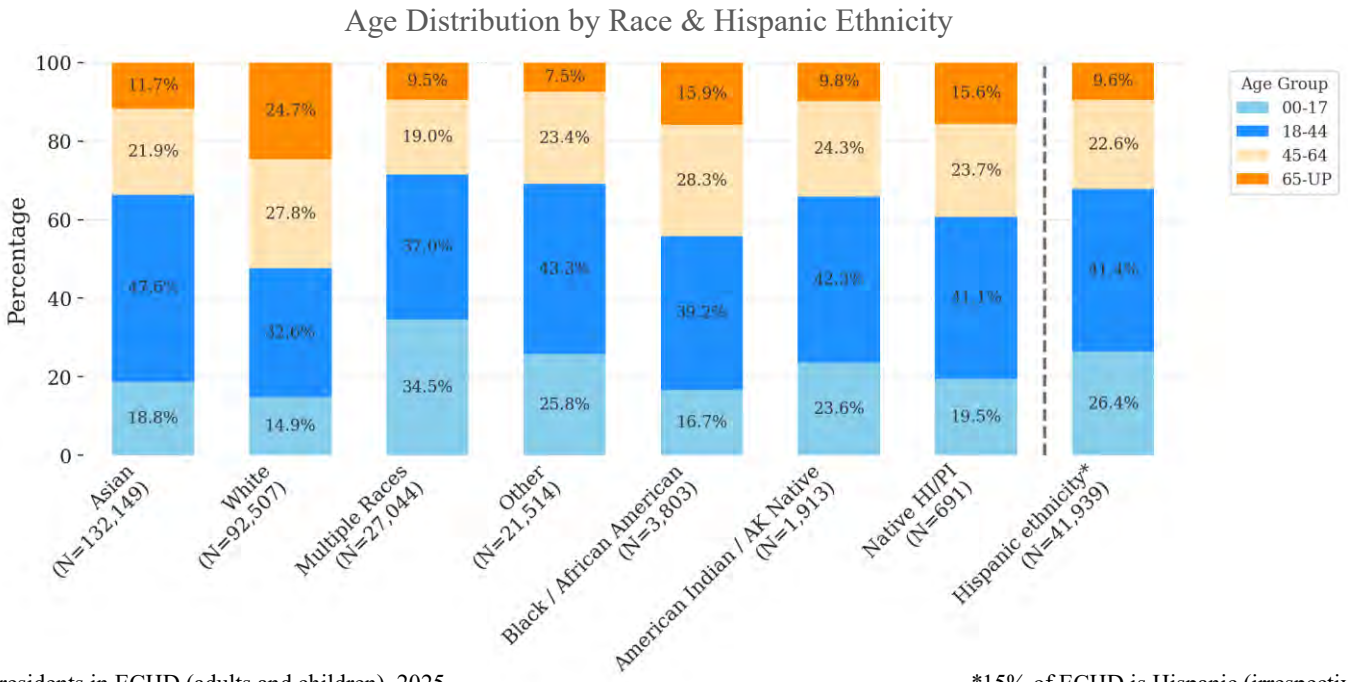
A prediabetes solution should consider ECHD diversity



Ref: Vizient/Sg2 data for all residents in ECHD (adults and children), 2025

*15% of ECHD is Hispanic (irrespective of Race)

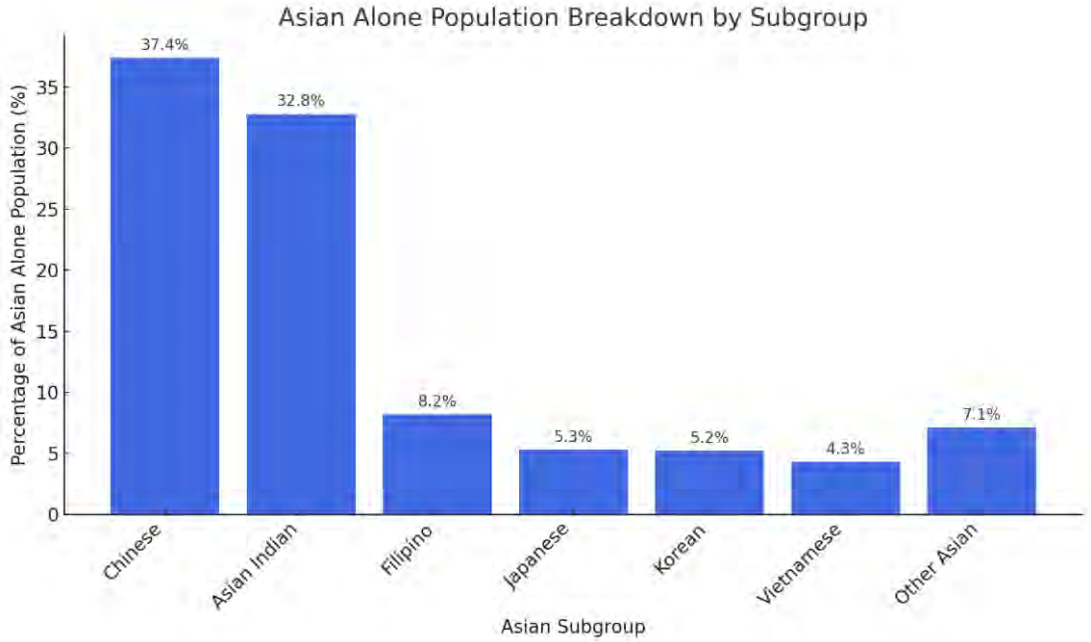
A prediabetes solution should consider ECHD diversity



Ref: Vizient/Sg2 data for all residents in ECHD (adults and children), 2025

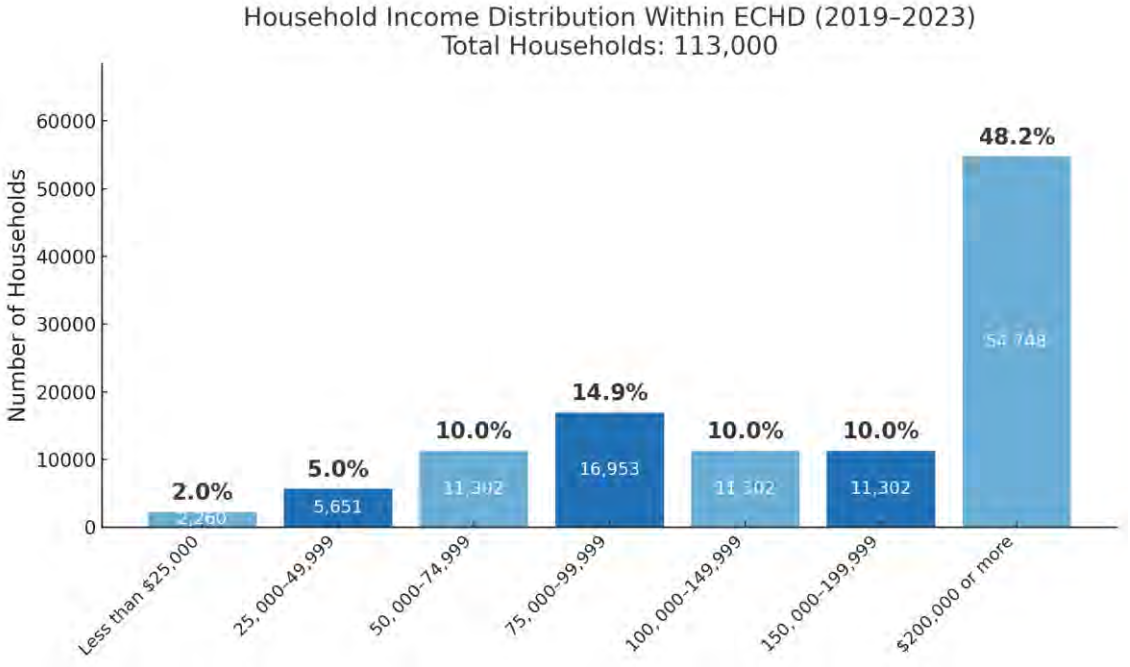
*15% of ECHD is Hispanic (irrespective of Race)

Asian race breakout



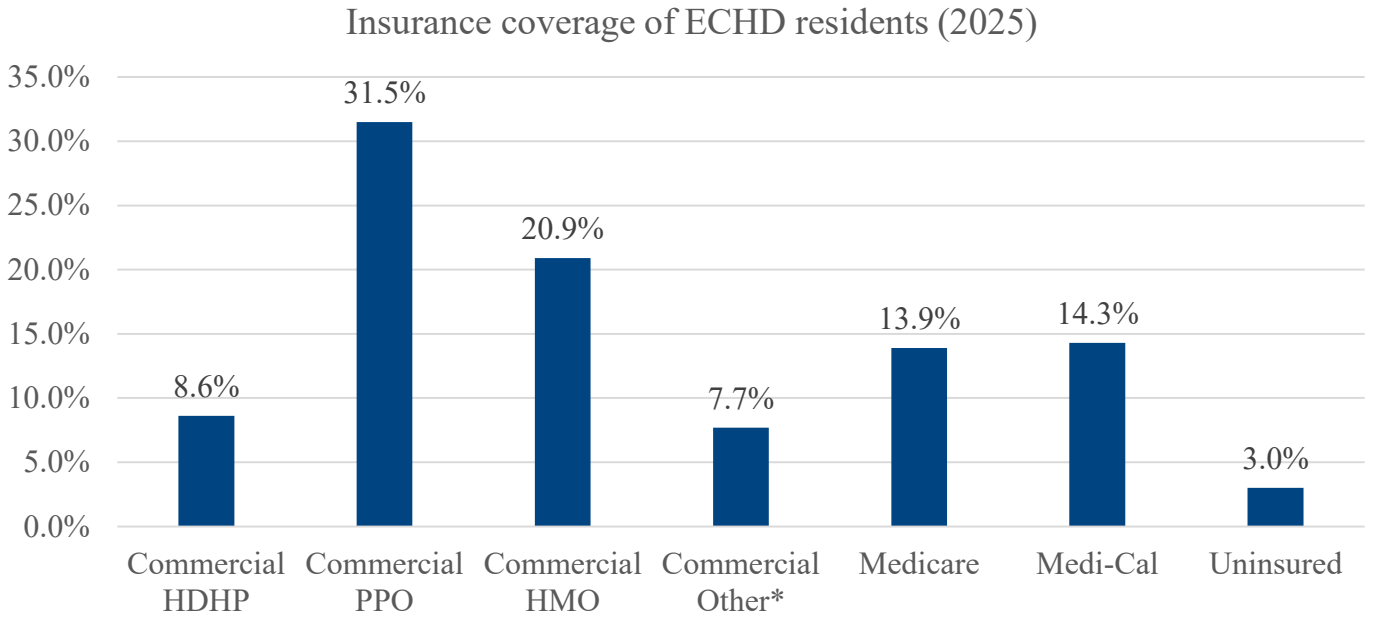
Ref: U.S. Census Bureau - American Community Survey (ACS) 5-year estimates (2018-2022)

Income distribution within ECHD



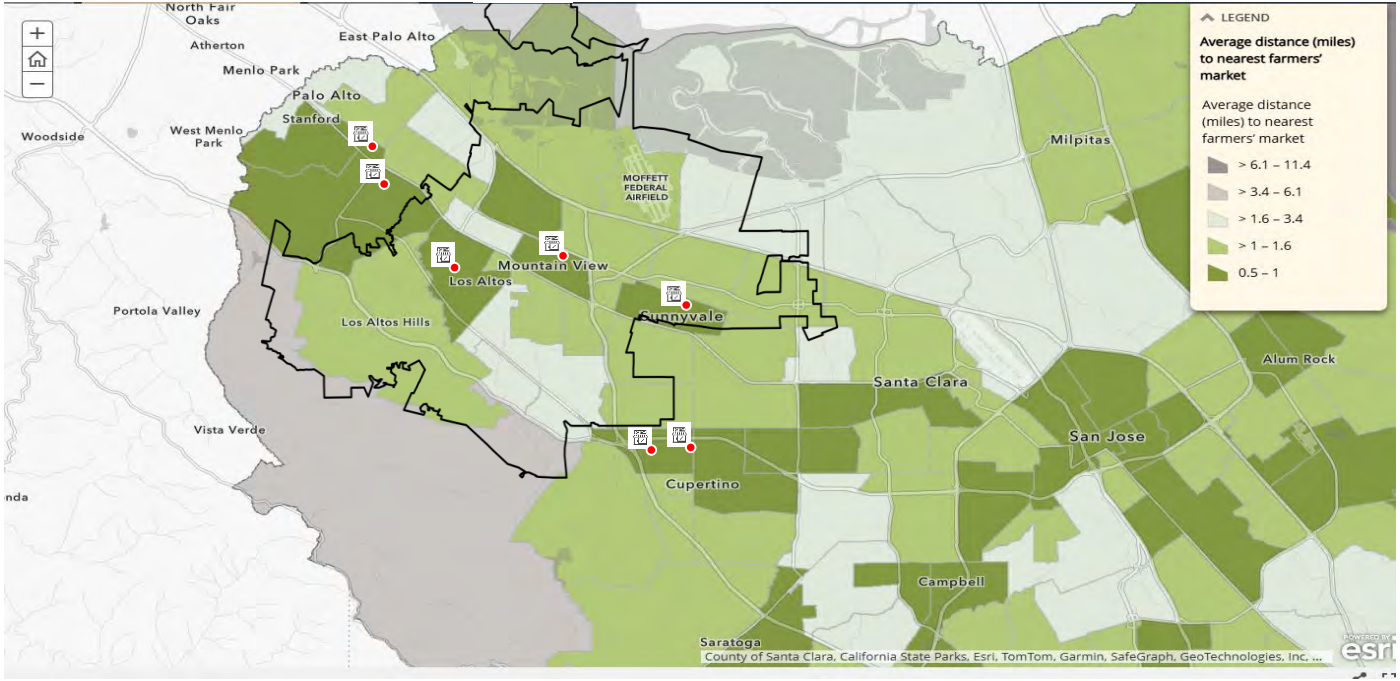
Ref: U.S. Census Bureau - American Community Survey (ACS) 5-year estimates (2019-2023)

Nearly 83% of ECHD residents are on commercial insurance or Medicare



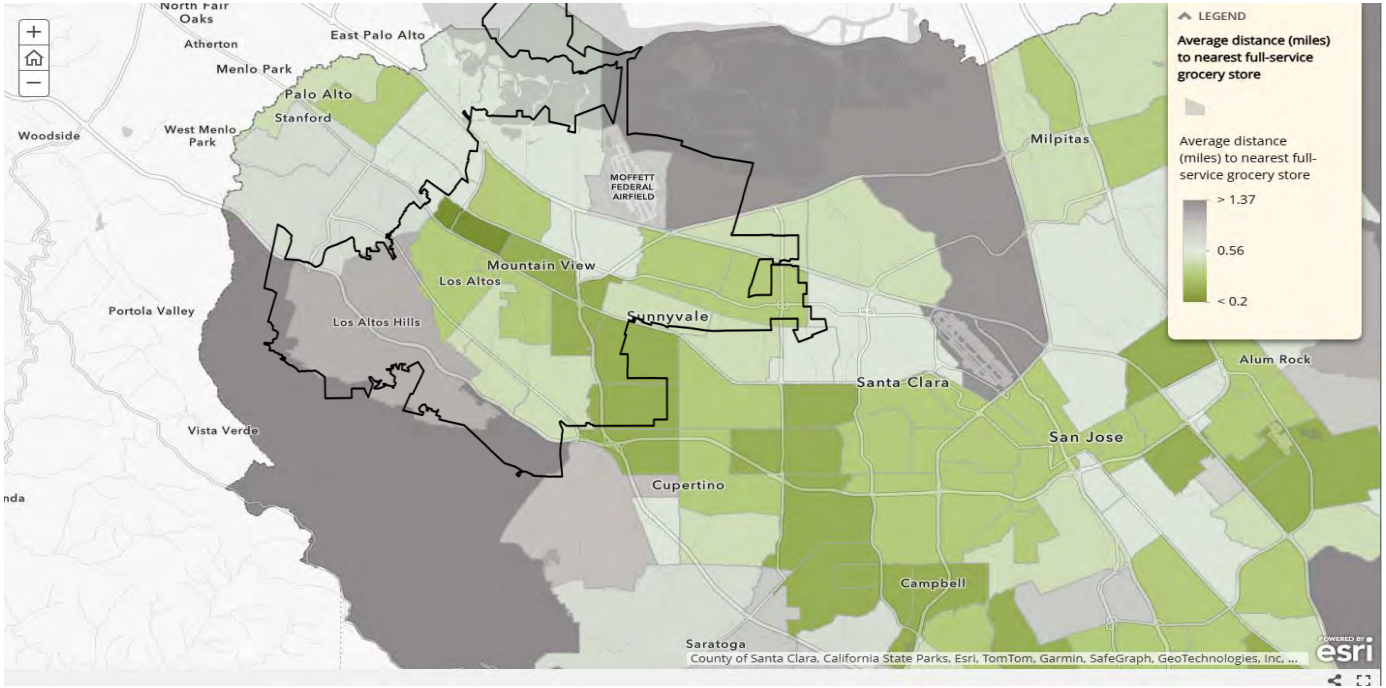
* "Other" includes: Indemnity, POS, Insurance Marketplace Subsidized Exchange, Insurance Marketplace Unsubsidized Exchange
Ref: Vizient/Sg2 data for all residents in ECHD (adults and children)

Many ECHD residents live within 1 mile of a farmers' market



Ref: Santa Clara County Public Health Dept, 2025

Almost all ECHD residents live within 1/2 mile of a grocery store



Ref: Santa Clara County Public Health Dept, 2025

Most ECHD grantees focus on youth and/or low-income adults/families

Diabetes & Obesity

American Diabetes Association: Project Power — Diabetes prevention program for youth ages 5-12 at school sites in Mountain View and Sunnyvale

Bay Area Women's Sports Initiative (BAWSI): BAWSI Girls in Sunnyvale — Physical activity and self-esteem program for 2nd through 5th grade girls in Sunnyvale School District

Bay Area Women's Sports Initiative (BAWSI): BAWSI Rollers in Sunnyvale — Adaptive physical activities for girls and boys with physical, cognitive, and hearing disabilities in Sunnyvale School District

Chinese Health Initiative — Culturally and linguistically competent hypertension, diabetes and cardiovascular disease screenings and education

City of Sunnyvale: Columbia Neighborhood Center – ShapeUp Sunnyvale — Fitness and nutrition education program for low-income families and youth

Community Health Partnership — Diabetes self-management workshop series for low-income adults in Mountain View

Fresh Approach — Farmers market voucher program, nutrition education, and resources for low-income community members

Living Classroom — Garden-based education to enhance food literacy in youth at Mountain View Whisman School District

Playworks — Physical activity and positive school climate program at Sunnyvale School District

Silicon Valley Bicycle Coalition: Bike to Health — Promoting physical activity in underprivileged youth and adults through instructor-led bike rides

South Asian Heart Center — Culturally competent heart disease and diabetes prevention program

YMCA of Silicon Valley — Summer camp programs for low-income youth focusing on physical activity and healthy eating

Ref: ECHD Community Benefit grants portfolio – grant summaries

Gaps and addressable market

	Context, Gaps, and Opportunities	Target Areas and Addressable market
What	• 45% of ECHD adults (and 26% of ECHD youth) are prediabetic. • Prediabetes is the top chronic condition among adults in ECHD. • ECHD grants support some in-person prediabetes/diabetes programming with youth/schools and low-income families.	• Members of ECHD of multiple different income levels and race/ethnicities could benefit from a **digital, individual self-management program, group programming, and/or youth-focused programming**. • Prediabetes risk rises with age, so adults are natural starting point.
Who	• More than **8 in 10 adults with prediabetes are unaware** that they have the condition. • ECHD can contribute to raising awareness about prediabetes, risk factor screening, and behavior/lifestyle change interventions.	• The **majority of ECHD residents are on commercial insurance** and are not necessarily low-income. • ECHD can partner with existing partners to stand up new or enhanced programming

How	• The main risk factors for prediabetes are obesity, poor nutrition, lack of physical activity, and genetics/family risks.
	• Food/nutrition is a strong candidate for intervention
	  • **Single behavior change is likely easier than multiple behavior changes**
	  • Everyone needs to eat
	  • Most residents have access to grocery stores and farmers' markets that offer healthy food choices
		• **"Food as Medicine" (ECH-labeled "Food is Health") is gaining popularity** as a lifestyle/behavioral approach for subclinical intervention and as a complementary intervention to clinical intervention, with good reason.
		• **Many virtual dietician approaches are covered under insurance** via "Medical Nutrition Therapy" coding.
		• Cooking and eating are social activities in many cultures, offering the chance for support/reinforcement

3-5 Year Population Health Strategy

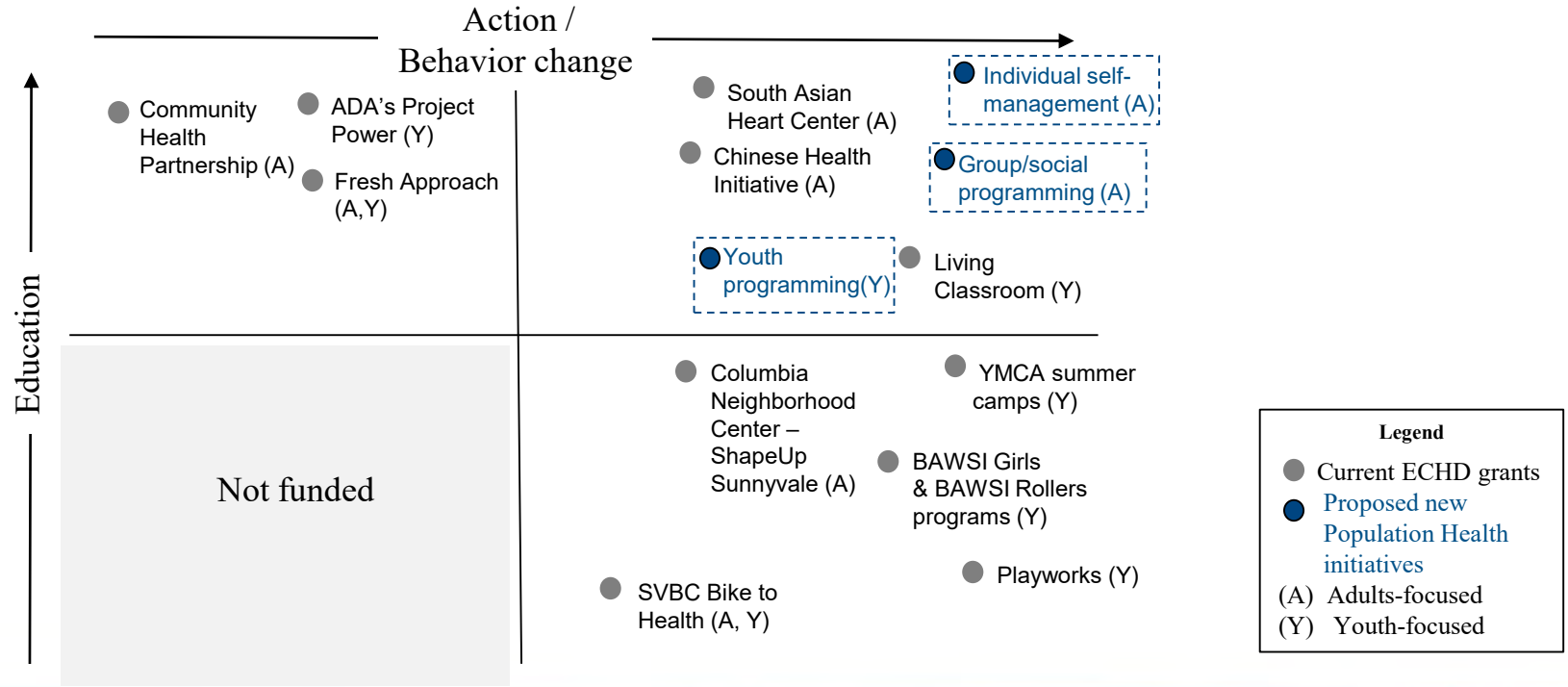
Proposed three-workstream approach

Workstream 1: Individual-self management for adults	Workstream 2: Group/social programming for adults	Workstream 3: Programming for youth

• **What:** Tech-forward solution to help people self-manage their own health and prediabetes risk
• **Key considerations**: Focus on Food is Health, single behavior change
• **Approach:** RFP for Food is Health vendor - includes virtual dietician appointments, goal setting, behavior & food tracking, biometric tracking
	• **What:** Group-based approach to enhance peer support effects
	• **Key considerations**: Maximize impact through collaborating with existing grantees and new partners to activate the network
	• **Approach*:** Investigate the most promising interventions for building social support and addressing time demands, e.g.
	  ◦ Healthy cooking and nutrition education
	  ◦ Peer support and coaching groups
	  ◦ Healthy eating challenge and rewards
		• **What:** Education-centric approach to encourage healthy habits in children and adolescents
		• **Key considerations**: Goal is to address healthy habits early, before chronic conditions start to develop
		• **Approach*:**
		  ◦ Partner with existing grantees or new partners
		  ◦ Consult the schools, camps, etc. on their desire for programming, what gaps exist

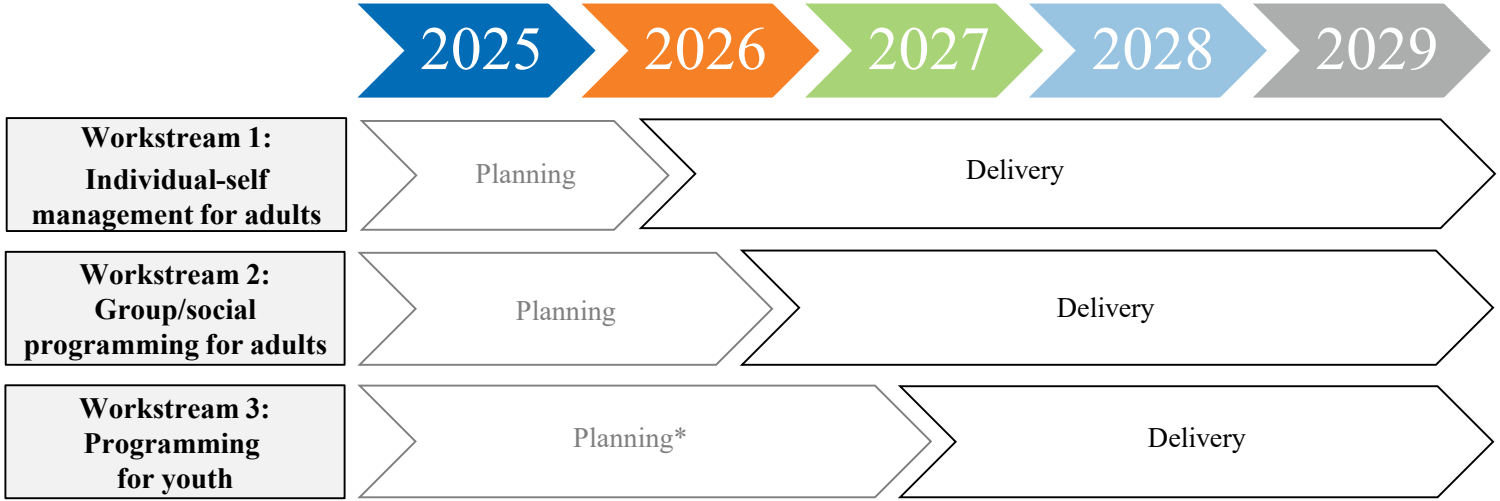
* Additional information on ideas to investigate in the slides that follow

ECHD portfolio of current and proposed programming



Roadmap and Timeline (Fiscal Year):

Program Planning and Delivery

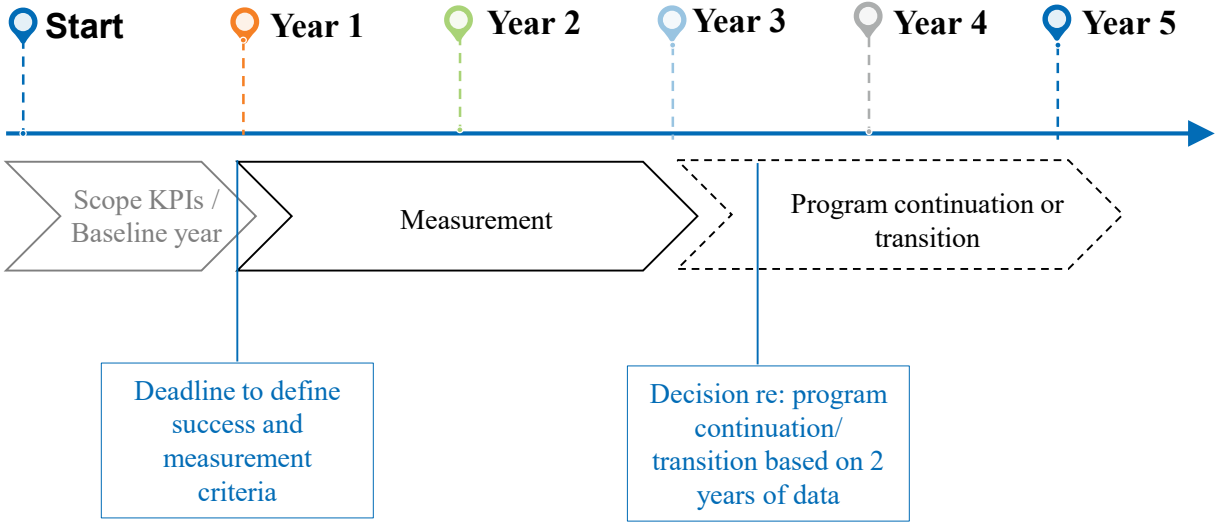


Planning phases: Analysis, Design, Fund

Delivery phases: Structure, Partner, Execute, Outreach, Evaluate, Iterate

* Planning in Workstream 3 is anticipated to last longer due to researching existing school offerings, assessing desire for partnership, creating alignment with the district and individual schools, and designing an appropriate and additive and supplementary programming.

KPIs and Measurement Framework



Scope KPIs / Baseline year: At the end of Year 1, evaluate/clarify KPIs, how define success, and measurement criteria
Measurement: Results at end of Year 3 for a 2-year retrospective period

KPIs and Measurement :

Defining Success & Measurement Criteria in Year 1

Intent	What we are doing in Year 1
Align on success metrics	• Define *what we're trying to change* (e.g. engagement, knowledge, behaviors) • Clarify outcomes that are **realistic** to expect within the time frame
Collaborate with vendor and partners	• Co-develop KPIs that are **meaningful, feasible, and measurable** • Identify what data is currently available vs. what needs to be collected • Ensure vendor and/or partner capacity to track and report data reliably
Establish baselines	• Begin data collection and establish pre-intervention baselines • Use this to determine change over time, rather than relying on assumptions
Address measurement logistics	• Confirm timing, frequency, and responsible parties for data collection • Ensure privacy, compliance, and integration with existing systems

Workstream 1: Individual self-management for adults [Program description]

- After a thorough vendor market assessment, as well as research/literature-based analysis of options, we identified the Food-is-Health (or Food-as-Medicine) category of vendor as the most well-aligned with the goals of our program and the ECHD population.
- A formal RFP process is in-progress with a final decision expected by end of FY2025.

Key Program element	Description	Empirical evidence examples / supporting literature	Fit for ECHD and additional considerations
"Food-is-Health" digital health offering	• Digitally-delivered nutrition and diet support from a Registered Dietitian • Program will be delivered primarily through digital interface, including virtual dietitian / nutrition coaching, goal setting, food tracking, biometric data integration, and more.	- Focusing on a single behavior change (vs. Multiple behavior changes) can increase uptake & adherence, reduce cognitive load, and increase self-efficacy, leading to a greater chance of success than other more intensive programs (1) - Single lifestyle change may be more feasible to promote (1,2,3) - Food-as-medicine / Food-is-Health as an approach is seeing increased investment, innovation and national focus	• Greater chance of reaching a broader audience & driving awareness • Food is approachable and relatable ("everybody eats") • Food-is-Health vendors have broader insurance coverage = better for ECHD cost management

Workstream 1: Individual self-management for adults [Measurement]

Measures of success will include a subset of the following:

- Enrollment, engagement, and retention metrics
- Knowledge of prediabetes risk factors and other education metrics, and awareness of prevention-based healthy lifestyle practices
- Awareness of their prediabetes status
- Adherence rates to diet & nutrition plans (e.g. servings of fruits and vegetables, water intake)
- Adherence to and consistency in recording meals, activity, and other metrics that are known to enhance program success
- Improvement in health measures (e.g. weight, glucose, HbA1C, via device integrations and/or self-reported outcomes)
- Cross-participation between programs in Workstream 1 (individual self-management) and Workstream 2 (group/social programming).
- Physician follow-up (e.g. likelihood of follow up with physician as result of program)

Workstream 1: Individual self-management for adults [Execution]

Staffing & Partnerships

- Director of Community Partnerships and ECHD Population Health Program Manager will continue to lead program management & execution
- Additionally, anticipate a need for Operations & Community Programming support, plus Marketing & Outreach support (future scoping will determine FTE vs. Consultant to staff these functions).

Facilities & Delivery Channels

- Program delivery for enrolled participants will be digitally/virtually-based
- Outreach will be conducted through a combination of channels. Possible ideas include: digital marketing, direct mail, A1C/glucose screening events & Health Risk Assessments.

Funding & Incentives

- Offset program cost by leveraging broad in-network insurance coverage from the chosen vendor
- Additionally, utilize ECHD Population Health funding to cover services when not covered by insurance
    - Note: anticipated cost per person of vendor program is comparable to many other ECHD-funded programs

Tech & Tools

- Primary tool will be the digital app-based program offered by the chosen vendor

Pilot, Measure, Scale

- In first year of program, enrollment of ~300 participants would be a success
- With proven, established outreach and enrollment channels, we can scale toward realistic goal of ~5-10% of eligible population enrolled over lifetime of program

Workstream 2: Group/social programming for adults [Program description]

Ideas to Investigate	Description	Empirical evidence examples / supporting literature	Fit for ECHD and additional considerations
Healthy cooking & nutrition education	- Hands-on cooking classes - Prediabetes-friendly recipes - Covers label reading, meal planning - Education on how to select healthy eating options if not cooking and eating out or getting food delivered	- Healthier meal prep and consumption; ↑ Veg intake, ↓ sugar/fats [1] - A1c improvements in virtual/in-person settings [2]	- High fit; peer-focused, engaging - Hosts: local restaurants, rec centers, library, stores, churches/religious organizations - Consider cultural tailoring (e.g. Latino/Asian meals) - Partner with local chefs or nonprofits
Peer support and coaching groups	- Trained peer mentors or group check-ins, buddy program for accountability - Share meals, goals, tips - Low-cost, potentially high engagement	- Boosts diet change & diabetes prevention program enrollment (2.4×↑) [3] - Improves self-efficacy, support [3]	- High fit; aligns with focus on peer support - Community-based or virtual - Leverage local diversity
Healthy eating challenge	- 4–6 week challenge to increase produce intake, water, or home-cooked meals - Points earned for logging meals, recipes, photos - Rewards: grocery gift cards, cookware, wellness swag	- Gamification & incentives improve diet engagement [4] - Weight loss & behavior change sustained better with goal tracking & social rewards [5]	- High fit; adds fun, social motivation layer - Can run online, via workplace, library, churches/religious organizations or other community gathering hub - Appeals to tech-savvy, goal-oriented populations

Workstream 2: Group/social programming for adults [Measurement]

Measures of success will include a subset of the following:

- Participation metrics (e.g. number of individuals who participate, number of repeat participants)
- Services delivered
- Self-reported increases in education and understanding of risk factors for prediabetes and development of diabetes
- Self-reported behavior change metrics
  - E.g. Proportion of participants making healthy food choices, Number of participants who report consuming at least 3 servings of fruits and vegetables per day
- Self-reported health outcome metrics for longer-term programs targeting behavior change
  - E.g. Self-reported improvement in health measures (e.g. weight, glucose, HbA1C)
- Cross-participation between programs in Workstream 1 (individual self-management) and Workstream 2 (group/social programming).
- Physician follow-up (e.g. likelihood of follow up with physician as result of program)

Workstream 2: Group/social programming for adults [Execution]

Staffing & Partnerships

- Leverage existing community health staff and partner with local RDs, chefs, peer coaches, and nonprofit orgs (e.g., YMCA, grantees)

Facilities & Delivery Channels

- Use ECHD partner spaces (e.g., libraries, rec centers, schools) for in-person programs
- Deliver virtual programs via Zoom, YouTube, or mobile-friendly platforms
- Leverage local grocers and farmers' markets for marketing

Funding & Incentives

- Utilize ECHD funds (Community Benefit, etc.) and explore additional funding sources
- Offer modest incentives (gift cards, meal kits, wellness swag) for participation and behavior tracking

Tech & Tools

- Use low-cost tools for tracking and engagement (e.g., Google Forms, Challenge Hound)
- Track participant outcomes via voluntary self-reporting or pre/post surveys

Pilot, Measure, Scale

- Start with 2–3 interventions as proof of concept (e.g., peer groups + cooking classes)
- Evaluate outcomes
- Scale up based on engagement, equity impact, and ROI potential

Workstream 3: Programming for youth [Program description]

- **Goal:** Build lifelong nutrition literacy to prevent chronic disease
- **Core themes:** Hands-on learning, peer leadership, cultural relevance
- **Approach**
  - Evaluate existing offerings, gaps, and opportunities.
  - Incorporate in-school lessons, after-school clubs, and family engagement.

Ideas to investigate	
• RD-led classroom visits + tasting challenges • Cooking & garden clubs • Family nights with simple recipes • Food + science tie-ins (e.g. sugar experiments) • Junior Chef Club, student-run garden stands	• Healthy habit challenges for families • Electives on food & health, student-led cafés • Culinary medicine clubs, peer nutrition leaders • Community expos led by teens • Subsidies for healthy school lunch choices

Workstream 3: Programming for youth [Measurement]

Measures of success will include a subset of the following:

- Participation metrics (e.g. number of individuals who participate, number of repeat participants)
- Services delivered
- Self-reported increases in education and understanding of risk factors for health
- Self-reported behavior change metrics
  - E.g. Proportion of participants making healthy food choices, Number of participants who report consuming at least 3 servings of fruits and vegetables per day
- Self-reported health outcome metrics for longer-term programs targeting behavior change
  - E.g. Self-reported improvement in health measures (e.g. weight)

Workstream 3: Programming for youth [Execution]

Staffing & Partnerships
- Hire part-time coordinator (RD or educator)
- Partner with school districts, PTAs, local chefs, garden orgs, grantees

Facilities & Delivery Channels
- Use classrooms, gardens, cafeterias, and after-school spaces
- Deliver programs during class, during school lunch, after school, and at family nights

Funding & Incentives
- Utilize ECHD funds (Community Benefit, etc.) and explore additional funding sources
- Offer participation rewards (meal kits, gift cards, certificates)

Tech & Tools
- Track engagement via surveys, photos, school newsletters
- Use simple tools (Google Forms, Canva, shared drives) for reporting

Pilot, Measure, Scale
- Launch in 3–5 schools (1 per level), refine based on feedback
- Track outcomes (knowledge, behavior change, participation
- Expand annually, embed in wellness policy

Outreach & Enrollment Strategy Across All Workstreams

- Digital health programs often rely on email outreach campaigns through employee contact / email lists
- Key difference for ECHD constituent population: we don't "own the patient" and therefore will need to be creative with our outreach
- Ideas for outreach & enrollment:
  - Digital & Print outreach campaigns (e.g., email, custom mailers, pamphlets, print collateral, ads)
  - In-person event tabling (e.g., health fairs, farmers markets, lobbies at YMCA or near hospital cafe)
    - We will consider the value of A1C/glucose screening and health risk assessments
  - Partnership with local municipalities, employers, and/or schools
    - We will explore partner referral channels, including ECH medical network
- We will use “personas” (examples of individuals who could benefit from the programming) to guide our approach, in addition to partnering with the community to understand needs, desires, and opportunities.

Program eligibility determination for adults*

* No screening for youth planned

Are lab results (self-reported or objective) available?

Yes

No

Does the participant have at least two risk factors (e.g. age, high BMI, family history, physical inactivity, high blood pressure)?

(Ref: Type2D risk quiz from ADA, a well-validated tool)

Does the value meet the threshold for prediabetes?

	A1c Test	Fasting Blood Sugar Test	Glucose Tolerance Test
Normal	Below 5.7%	99 mg/dl or above	140 mg/dl or above
Prediabetes	5.7-6.4%	100-125 mg/dl	140-199 mg/dl
Diabetes	6.5% or above	126 mg/dl or above	200 mg/dl or above

Ref

No

Yes

No

Yes

Not eligible

Eligible

Next Steps and Dialogue

What to expect going forward

- **Cadence**
  - Updates will be provided to the ECHD Board twice per fiscal year (March and October).
- **Content**
  - Performance dashboard:
    - Outcomes and metrics for current period (v.s. prior period when available/applicable), e.g.:
      - Number enrolled
      - District funds used
    - Operational (internal ECH, vendor) and execution (community-facing implementation) “successes” and “learnings”/areas of opportunity
  - Next steps
    - Anticipated challenges
    - Planned mitigations
  - Dialogue

Dialogue prompts

Objective: To gather individual board feedback on the El Camino Healthcare District's Population Health and prediabetes strategy and program design. To allow each board member to answer the following questions:

1. Are there any additional factors that should be considered in the Roadmap for the Population Health Strategy?
2. What aspects of the Population Health strategy and prediabetes program design have we not considered?
3. What additional aspects of the Population Health measurement approach should be considered for FY2026 and beyond?
4. What would you like to see from a reporting standpoint approximately every six months?

Appendix

Anticipated interactions with existing programs & initiatives

- Approximately ~30% of the addressable population is either South Asian or Chinese, and we expect will potentially overlap with the target populations of the South Asian Heart Center (SAHC) and Chinese Health Initiative (CHI)
- Staff have engaged in initial conversations with SAHC and CHI program leads about possible ways these programs could leverage opportunities to both supplement and complement existing programs.

Workstream	Opportunity for collaboration	Description
Workstream 1 – Vendor Self-Management for adults	**Yes, complementary**	• Expected program design differs in intervention style and intensity (SAHC core DPP program is a more intensive program; CHI is predominantly group-based and doesn't include 1:1 coaching; neither program is digital/virtual-first) • Opportunity for cross-referrals since CHI and SAHC don't currently have a nutrition-specific curricula
Workstream 2 - Group / social programming for adults	**Yes, supplementary**	• Existing group-based elements for CHI and SAHC could serve as model for some group / social programming • Opportunity for joint group-based programming, particularly if continuing Food-is-Health focus in Workstream 2
Workstream 3 – Programming for youth	**Unlikely**	• Workstream 3 is focused on youth, and therefore is unlikely to target existing populations served by SAHC or CHI

Key Learnings from Research

Topic	Learnings	Details	Implications
Single behavior change v.s. Multiple Behavior changes	• Multiple behavior interventions are more effective for reducing prediabetes risks and Type 2 diabetes risks, but only if engagement and adherence to interventions remains high (1, 2). • Single behavior change interventions may have more uptake and adherence, and more success of dietary or physical activity change (independently), due to the lower cognitive load and higher self-efficacy (3,4,5).	• Focusing on one behavioral change at a time may be more achievable for most people - interventions targeting a single behavior reduce cognitive burden and facilitate long-term maintenance of change (3). • A synthesis of meta-analysis found that single behavior interventions resulted in larger and more reliable effect sizes for changing behaviors than combined approaches (4). • Another study compared automated interventions for four groups: diet only, physical activity only, diet + physical activity, and a control group (5). They found that the diet only intervention was effective and produced a greater intake of fruits and vegetables compared to the combined diet + physical activity intervention.	✓ Utilize a single behavior change intervention to increase uptake and adherence, reduce cognitive load, increase self-efficacy and lead to a greater chance of success for individual behavior change.

Key Learnings from Research

Topic	Learnings	Details	Implications
Enrollment and engagement	• Significant outreach efforts with multiple contact attempts are often required to engage individuals in behavioral and lifestyle change programs, regardless of modality (in person or mHealth) (9,10). • Invitations and endorsement from trusted providers, professionals, community members, family members, and friends can encourage engagement (11,12).	• Even after receiving multiple reminders, some individuals reported waiting months or years before enrolling in a lifestyle-change program, citing time constraints or not feeling "ready." (9, 10). In the NHS digital DPP in the UK, providers sent monthly email and letter reminders to people who initially declined or didn't respond (11). This persistent outreach was necessary to capture additional participants. • Endorsement by trusted professionals can yield greater enrollment rates. For example, the NHS digital DPP in the UK contacted 2,051 eligible individuals, yielding only about a 3% initial expression of interest (11). When personal invitations came via patients' own primary care practice (a presumably more trusted source), response rates were higher (~11%) (11). This suggests that trusted, personalized channels (like one's doctor's office) may increase the likelihood of signup.	✓ Leverage repeated and multi-channel contacts (emails, letters, calls, in-person prompts), which are often needed to recruit participants. ✓Use trusted messengers (like personal physicians or community leaders) to greatly enhance the likelihood that individuals will enroll in digital behavior change programs. ✓ Focus on one single, compelling lifestyle change (e.g., targeted healthy-eating initiative), as it may be more feasible to promote, especially if a program has limited resources for repeated messaging and follow-up.

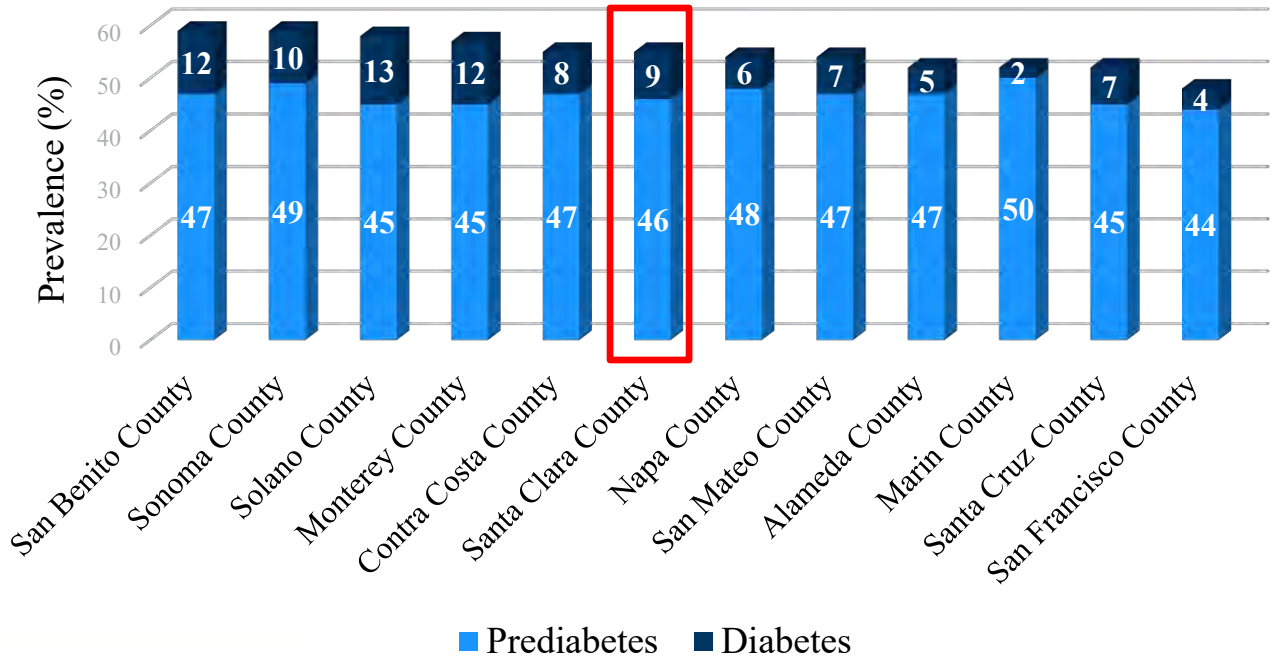
Key Learnings from Research

Topic	Learnings	Details	Implications
Motivation after prediabetes diagnosis	• Over 8 in 10 people with prediabetes aren't aware they have the condition (13). • People often become more motivated after discovering they have prediabetes (14), but enrollment may still be modest unless a program is easy to access and emphasizes the seriousness and manageability of prediabetes (15,16,17).	• The label of "prediabetes" can have varying psychological effects. For some, it increases motivation – it's a wake-up call that spurs them to improve their diet or activity (14). For others, it may induce anxiety or fatalism (worrying about developing diabetes, or conversely, feeling the outcome is inevitable) (14). Thus, the way the diagnosis is communicated is important: patients benefit from hearing that *prediabetes is a reversible condition*, not a guaranteed path to diabetes. • Studies show that many individuals may not fully understand prediabetes or feel it's urgent or important enough to trigger immediate changes (14). In some instances, people might downplay the risk ("it's not *real* diabetes yet") or feel unsure what to do, leading to inaction. This indicates that additional support and guidance are needed beyond the diagnosis conversation (14). • A meta-synthesis across twenty studies (including 552 individuals) noted multiple factors in motivation. And chief among them was understanding the importance and relevance of the diagnosis (15). • Patients must understand that prediabetes is reversible through lifestyle and behavioral changes and understand the value a prevention program could provide to them (16). • Programs must have minimal barriers (e.g., cost, referral mechanism, accessibility, convenience) (17).	✓ Focus on those who already know they have prediabetes, as they tend to be more motivated, especially if the intervention removes or mitigates key barriers (cost, time, etc.). ✓ If able, reach the undiagnosed or newly diagnosed population, as this could be high-impact (but could require more investment in education and outreach). ✓Outreach should be: tailored and relevant, appeal to individuals to take action, emphasize convenience and ease along with low barriers to engagement.

Key Learnings from Research

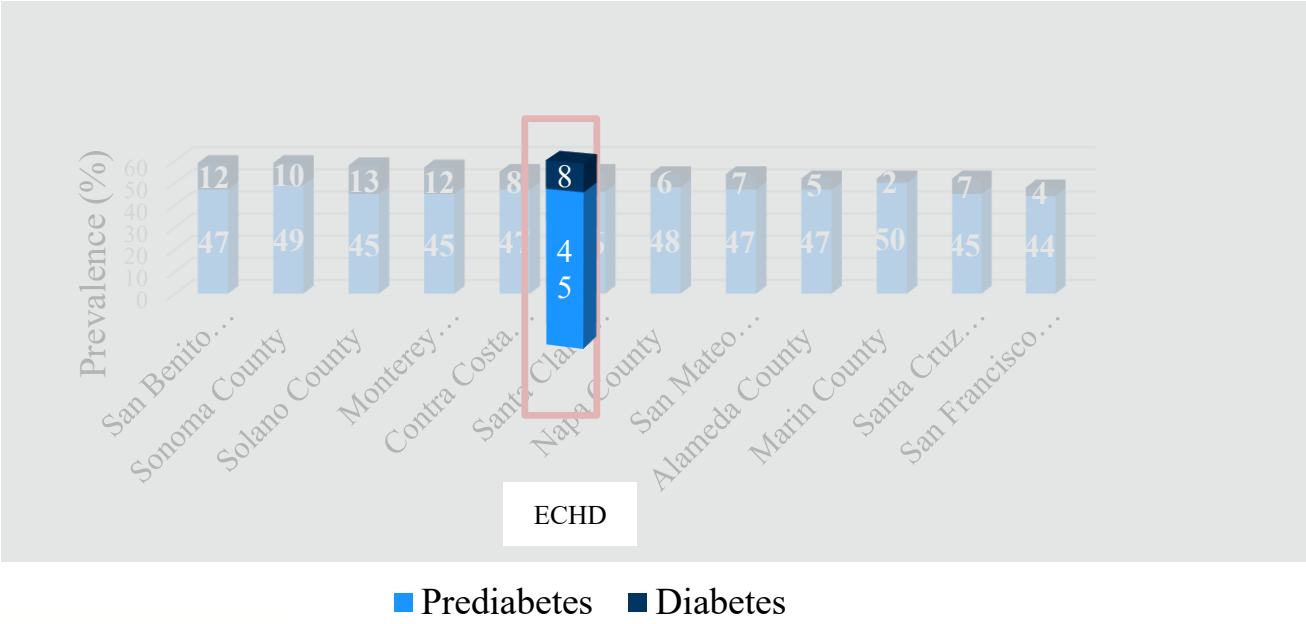
Topic	Learnings	Details	Implications
Best practices for program tools and support resources	• The design quality, usability, and available support systems in a digital prediabetes program significantly impact sign-up rates, engagement, and retention (18,19,20). Features like health coaching, self-monitoring tools, and peer support boost adherence, while fully automated interventions often see lower participation rates (19).	• **User-Friendly Design & Perceived Effectiveness Matter**: If an app is hard to use or doesn't demonstrate clear benefits, users are less likely to sign up and stay engaged (18). • **Health Coaching & Self-Monitoring Increase Retention**: Digital diabetes prevention apps that integrate coaching, personalized goal tracking, and progress visualization improve long-term engagement (19). • **Social Support Enhances Accountability**: Programs with peer forums, group chats, or coach interactions result in higher adherence compared to isolated, self-guided interventions (19). • **Human Interaction (Even Remote) Boosts Success**: Regular check-ins via phone, video, or chat create a sense of accountability and motivation, improving program retention (19). • **Incentives and personalized nudges are important**: A scoping review assessing remote digital health studies found that providing incentives or nudges, such as regular reminders and personalized feedback, led to increased study completion rates. Specifically, studies that implemented these strategies observed a median completion rate of 62%, compared to lower rates in studies without such interventions (20).	✓ Prioritize an intuitive, engaging app design to reduce friction in user experience. ✓ Integrate coaching or real-time feedback features to guide participants. ✓ Include peer support groups or community features for accountability and motivation. ✓ Leverage human touchpoints (text, call, video chat) rather than relying solely on automated approaches. ✓ Consider integration with wearables a "nice-to-have", not a requirement.

Prevalence of Prediabetes by county



Ref: https://healthpolicy.ucla.edu/publications/Documents/PDF/2016/prediabetes-brief-mar2016.pdf

Prevalence of Prediabetes in ECHD



Ref: https://healthpolicy.ucla.edu/publications/Documents/PDF/2016/prediabetes-brief-mar2016.pdf

Utility of Prevalence in Population Health Strategy

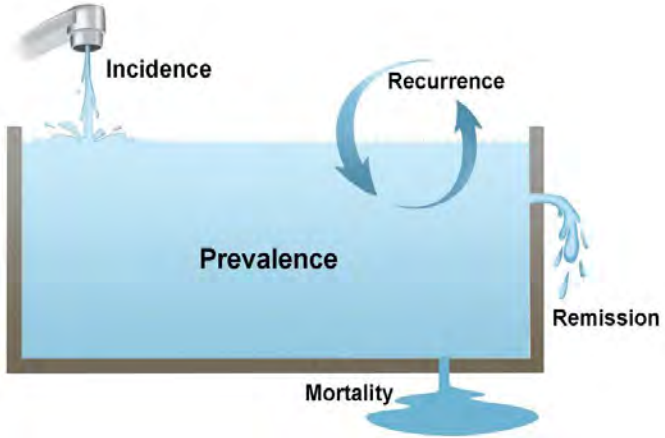


Image ref: https://theromefoundation.org/what-can-we-learn-from-epidemiological-studies/

Incidence:
The number of **new cases** of a disease that develop in a specific population over a defined period of time.

Prevalence:
The total number of **existing and new cases** of a disease in a specific population at a given point in time or over a period of time.

Mortality:
The number of **deaths** caused by a disease in a specific population over a period of time.

Prevalence provides a snapshot of the total burden of a condition in a population, making it essential for prioritizing resources, planning interventions, and addressing chronic diseases like diabetes or prediabetes. Unlike incidence, which tracks new cases, prevalence better reflects the ongoing need for management and prevention efforts. Mortality is a reflection of the effectiveness of treatment and providers/healthcare systems.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Shreyas Mallur, MD, Chief Quality
Jon Cowan, Executive Director, Government Relations & Community Partnerships
Date: June 17, 2025
Subject: Community Vaccination Partnership

Purpose: For the board to endorse the use of ECHD funds, if it becomes necessary to use such funds, in order to partner with Santa Clara County Public Health to support contact testing or vaccination efforts to protect against the outbreak of measles or other vaccine-preventable diseases of concern.

Background:
At the May 20, 2025 District Board meeting, directors discussed the potential for El Camino Healthcare District to support a community vaccination initiative operated by El Camino Health if needed in response to several recent measles outbreaks in other parts of the country and rising concerns about vaccine-preventable diseases. The directors were briefed on the current efforts that Santa Clara County Public Health is undertaking in order to detect cases, contact test, and administer vaccinations if necessary.

County Partnership Opportunity:
Santa Clara County Public Health shared their current approach to address the measles situation and prepare for positive cases. The approach includes:

1. **Case Detection:** Supporting the identification and monitoring of confirmed or suspected cases.
2. **Contact Testing:** Conducting rapid testing of individuals with known exposure to test for antibodies.
3. **Vaccination Access:** Providing timely access to key immunizations for those with a known exposure.
4. **High Consequence Infectious Disease Drills at ECH :** Conducting drills to test readiness to respond to highly communicable diseases at ECH in partnership with the County.

In the near-term, Santa Clara County Public Health shared that El Camino Health may be able to be a resource in helping to run serology tests for measles, depending on where cases are detected geographically and the number of individuals who have to be rapidly tested.

Recommended Approach:
To reiterate to Santa Clara County Public Health that El Camino Health remains ready to partner around contact testing and vaccination efforts. To communicate that the ECHD board has expressed its desire to fund such efforts if they become necessary.

If Santa Clara County Public Health requests contact testing or vaccination assistance from ECH and ECHD funds are used to support such efforts, reports will be shared with the ECHD board.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: June 17, 2025
Subject: El Camino Healthcare District (ECHD) Budget Fiscal Year 2026 and Allocation of M&O Tax Funds

Purpose: To review and approve the Fiscal Year 2026 operating budget and allocation of M&O tax funds.

FY2026 Operating Budget Summary – El Camino Healthcare District (stand-alone)

El Camino Healthcare District's (stand-alone) FY2026 operating budget anticipates the following revenues and expenses:

- **Total Revenues:** **$28.4 million**
  - M&O Property Tax: $27.2 million
  - Property Tax Debt Service: $ 2.7 million
  - Investment Income: $ 3.0 million
  - IGT Funding: ($ 4.9 million)
  - All Other: $ 0.4 million

- **Total Expenses:** **$18.6 million**
  - Community Benefit Program: $ 10.0 million
  - G.O. Bond Interest Expense: $ 7.7 million
  - All Other: $ 0.9 million

FY2026 Operating Budget Summary – ECHD and Affiliates (Consolidated)

The consolidated FY2026 operating budget anticipates total operating revenues of $1.82 billion and total operating expenses of $1.67 billion.

The table below includes the trajectory of revenues and expenses from FY2024 to BudgetFY2026 ($000s).

	FY2024 Actual	FY2025 Projected	FY2026 Budget	Change Favorable/ (Unfavorable)	% Change
REVENUES					
Net Patient Service Revenue	1,477,848	1,621,455	1,746,810	125,355	7.7%
Other Operating Revenue	76,713	68,995	72,796	3,800	5.5%
Total Net Revenue	1,554,561	1,690,450	1,819,605	129,155	7.6%
EXPENSES					
Salaries & Benefits	782,120	868,286	948,745	(80,459)	(9.3%)
Supplies & Other Expenses	520,334	550,755	620,801	(70,045)	(12.7%)
Interest	17,674	17,582	20,629	(3,048)	(17.3%)
Depreciation/Amortization	83,249	84,126	82,693	1,433	1.7%
TOTAL EXPENSES	1,403,377	1,520,749	1,672,868	(152,119)	(10.0%)
OPERATING INCOME	**151,183**	**169,701**	**146,738**	**(22,964)**	**(13.5%)**
Non Operating Income	178,590	167,923	72,552	(95,372)	(56.8%)
NET INCOME	**329,774**	**337,624**	**219,289**	**(118,335)**	**(35.0%)**
Operating EBIDA	*252,107*	*271,409*	*250,060*	*(21,349)*	(7.9%)
EBIDA Margin Percentage	*16.2%*	*16.1%*	*13.7%*		
Operating Margin Percentage	*9.7%*	*10.0%*	*8.1%*		

ECHD – Budget FY2026 and Allocation of M&O Tax Funds
June 17, 2025

Recommendation:

- To approve and adopt the Fiscal Year 2026 operating budget and allocation of M&O tax funds as recommended by management.

List of Attachments:

- El Camino Healthcare District Fiscal Year 2026 Budget Presentation

Dedicated to improving the health and well being of the people in our community.

El Camino Healthcare District
Fiscal Year 2026 Budget

Carlos Bohorquez
Chief Financial Officer

June 17, 2025

Basis of the El Camino Healthcare District FY2026 Budget

- ***The District budget is first shown in "stand-alone" format, including those transactions which occur at the District level.***

  - This presentation will cover the assumptions driving the District's budget and will provide information on District–level revenues and expenditures.

  - The preliminary budget for El Camino Hospital and its affiliates was reviewed at the April finance committee meeting. Additional information on the budget for El Camino Hospital and its affiliates is available on the hospital's website (www.elcaminohospital.org).

- ***The District budget is also shown in consolidated format in this presentation as it is the District's responsibility to approve the consolidated budget.***

Key Assumptions – El Camino Healthcare District

- Other Operating Revenue is based on the existing ground lease agreement.
- The Unrestricted M&O Property Taxes are budgeted based upon the Tax Appropriation Limit (Gann Limit).
- This year the Redevelopment Agency revenues were once again budgeted as they continue to be distributed by the County without any lapse in payments in the past years.
- Operating Expenses are based on historical payment information with adjustments made for non-recurring expenses.
- Community Benefit Support fee based on the cost of services as follows:

Community Partnerships Staff FY2026	Total Paid FTEs	
Exec Director Govt Relations & CP		1.00
Director Community Partnership		1.00
Administrative Coordinator		1.00
Sr Community Benefit Specialist		2.00
Total		5.00
Total Salaries, Wages & Benefits	$	925,926
Estimated allocation of time at 54%	$	500,000
FY 2025 allocation	$	422,067
FY 2024 allocation	$	357,582
FY 2023 allocation	$	357,582

- District's budgeted dues are expected to remain a constant of LAFCO at an amount of $15,000 and $9,000 for California Special Districts Association.
- Expenses related to the G.O. bonds are based on the 2006 and 2017 G.O. Refunding outcomes and required payment schedules.
- Investment income is based on the expected return rate provided by our Investment Consultant of on an average cash balance of $40M.
- Community Benefit expenditures are based on the Community Benefit plan.
- IGT – Medi-Cal (PRIME) program - It is expected that the District/Hospital will participate in the program again this year.

El Camino Healthcare District
Comparative Income Statement
($000s)

	FY2024 Actual	FY2025 Projected	FY2026 Budget	Change Favorable/ (Unfavorable)	% Change
REVENUES					
Other Operating Revenue	$112	$114	$117	$3	2.7%
Total Net Revenue	112	114	117	3	2.7%
EXPENSES					
Salaries & Benefits	16	23	61	(39)	(170.2%)
Non-Medical Supplies	0	0	0	0	
Admin and Consulting Fees	10	0	0	0	0.0%
Purchased Services	460	1,250	822	428	34.2%
Depreciation/Amortization	5	5	5	0	9.1%
Other General and Administrative	57	53	55	(2)	(3.7%)
TOTAL EXPENSES	549	1,331	943	388	29.1%
OPERATING INCOME	**($437)**	**($1,217)**	**($826)**	**$391**	**(32.1%)**
Non Operating Income	16,614	13,491	10,602	(2,889)	(21.4%)
NET INCOME	**$16,177**	**$12,274**	**$9,776**	**($2,498)**	**(20.4%)**
Operating EBIDA	*(431)*	*(1,211)*	*(821)*	*392*	(32.3%)
EBIDA Margin Percentage	*(384.3%)*	*(1059.2%)*	*(699.0%)*		
Operating Margin Percentage	*(389.1%)*	*(1063.8%)*	*(703.1%)*		

El Camino Healthcare District
Trajectory - FY2024 to Budget FY2026
Information excludes El Camino Hospital & its affiliates
($000s)

	Revenues	FY2024 Actual	FY2025 Projected	FY 2026 Budget	Change Favorable / (Unfavorable)	% Change
(A)	Other Operating Revenue	112	114	117	3	2.6%
(B)	Unrestricted M&O Property Taxes	11,048	11,450	11,450	-	0.0%
(B)	Restricted M&O Taxes	14,278	15,266	15,750	484	3.2%
(B)	Taxes Levied for Debt Service	7,920	2,700	2,700	(0)	0.0%
(B)	Investment Income (net)	3,484	3,115	3,000	(115)	-196.3%
(B)	Other - Redevelopment Agency	246	250	250	-	0.0%
(B)	IGT Medi-Cal Program Expense	(6,093)	(4,885)	(4,885)		
	Total Net Revenue	30,995	28,011	28,382	371	1.3%
	Expenses					
(A)	Community Benefit Support	358	422	500	(78)	18.5%
(A)	Fees & Purchased Services	102	787	322	465	144.4%
(A)	Supplies & Other Expenses	84	117	116	1	0.9%
(A)	Depreciation/Amortization/Interest Expense	5	5	5	0	10.0%
(B)	G.O. Interest Expense (net)	6,796	7,124	7,663	(539)	-7.0%
(B)	Community Benefit Program	7,473	7,282	10,000	(2,718)	-27.2%
	Total Expenses	14,818	15,737	18,606	(2,869)	-15.4%
	NET INCOME	16,177	12,274	9,776	(2,497)	-20.3%

	FY26 BUDGET RECAP STATEMENT OF REVENUES & EXPENSE	
(A)	Net Operating Revenues & Expenses	(826)
(B)	Net Non-Operating Revenues & Expenses	10,602
	NET INCOME	9,776

El Camino Healthcare District
Statement of Fund Balance Activity for Budget FY2026

Information excludes El Camino Hospital & its affiliates

($000s)

UNRESTRICTED FUND ACTIVITY BALANCE

Projected Opening Balance at 7/1/2025	$72,109
Budgeted Net Income for FY2026	9,776
Hospital Refunds for IGT / Prime Expenditures in FY26	4,885
Projected Transfer to ECH for Capital Outlay Projects	(13,045)
FISCAL YEAR 2026 ENDING BALANCE	**$73,725**

El Camino Healthcare District

Sources & Uses of Tax Receipts ($000s)

Budget FY2026

Sources of District Taxes	**Sources**	**Balance**
(1) Maintenance and Operation and Government Obligation Taxes	$29,900	
(2) Redevelopment Agency Taxes	$300	
Total District Tax Receipts		**$30,200**
Uses Required Obligations / Operations	**Uses**	**Balance**
(3) Government Obligation Bond (Principal & Interest & Surplus)	$10,556	
Total Cash Available for Operations, CB Programs, & Capital Appropriations		19,644
(4) Capital Appropriation Fund – Excess Gann Initiative Restricted*	7,423	
Subtotal		12,221
(5) Operating Expenses (net)	938	
Subtotal		11,283
(6) Capital Replacement Fund (Park Pavilion)	5	
Funds Available for CB and Operations		**$11,278**

(1) M&O and G.O. Taxes	• Cash receipts from the 1% ad valorem property taxes and Measure D taxes
(2) Redevelopment Agency Taxes	• Cash receipts from dissolution of redevelopment agencies
(3) Government Obligation Bond	• Levied for debt service
(4) Capital Appropriation Fund	• Excess amounts over the Gann Limit are restricted for use as capital
(5) Operating Expenses	• Expenses incurred in carrying out the District's day-to-day activities
(6) Capital Replacement Fund	• Fund to ensure that the District has adequate resources to fund repair and replacement of its capital assets (Park Pavilion at 130% of original cost)

El Camino Healthcare District – CONSOLIDATED Budget FY2026

($000s)

	Standalone	El Camino Hospital	El Camino Hospital Affiliates	Total
REVENUES				
Net Patient Service Revenue	$0	$1,631,541	$115,268	$1,746,810
Other Operating Revenue	117	38,849	33,829	72,796
Total Net Revenue	117	1,670,390	149,098	1,819,605
EXPENSES				
Salaries & Benefits	61	892,191	56,492	948,745
Supplies & Other Expenses	877	479,413	140,510	620,801
Interest	0	20,629	0	20,629
Depreciation/Amortization	5	79,620	3,069	82,693
TOTAL EXPENSES	943	1,471,853	200,071	1,672,868
OPERATING INCOME	**($826)**	**$198,537**	**($50,974)**	**$146,738**
Non Operating Income	10,602	58,399	3,551	72,552
NET INCOME	**$9,776**	**$256,935**	**($47,422)**	**$219,289**
Operating EBIDA	*(821)*	*298,786*	*(47,905)*	*250,060*
EBIDA Margin Percentage	*(699.0%)*	*17.9%*	*(32.1%)*	*13.7%*
Operating Margin Percentage	*(703.1%)*	*11.9%*	*(34.2%)*	*8.1%*

El Camino Healthcare District - CONSOLIDATED

Trajectory - FY2024 to Budget FY2026

($000s)

	FY2024 Actual	FY2025 Projected	FY2026 Budget	Change Favorable/ (Unfavorable)	% Change
REVENUES					
Net Patient Service Revenue	1,477,848	1,621,455	1,746,810	125,355	7.7%
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Operating Margin Percentage	*9.7%*	*10.0%*	*8.1%*		

Proposed Motion

- To approve and adopt the Fiscal Year 2026 operating budget and allocation of M&O tax funds as recommended by management

Q & A

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: Carlos Bohorquez, Chief Financial Officer
Michael Walsh, Controller
Date: June 17, 2025
Subject: Draft Resolution 2025 - 08 Establishing Tax Appropriation Limit for FY2026 (Gann Limit)

Purpose: To approve Resolution 2025 - 08

Summary:

1. **Situation:** Annually, the District Board must set the Tax Appropriation Limit (Gann Limit) for the following fiscal year.

2. **Background:** Every May 1st, the Department of Finance of the State of California sends a letter to all Fiscal officers regarding "Price and Population Information". Since FY 2008/2009 we have been required to use the California Department of Finance – Demographics website link which provides the variables for cost-of-living factors and population changes from the prior year from which we select to calculate the Prop. 13 Tax Appropriation Limit.

   Management's selections were made to maximize the funds available for Community Benefit Programs and the operational expenses of the District.

   A. Cost of Living Category:
   - The change in California's per capita personal income from the preceding year was a positive 6.44%.
   - The percentage change in local assessment is due to non-residential new construction from the previous year. This change is no longer provided.

   Management selected the % change in per capita personal income of a positive 6.44% (1.0644)

   B. Change in Population
   - The population change within the District was a positive 0.0028%.
   - The population change within the County was a positive 0.0004%.

   Management selected the District's change: 0.0028% (1.0028)

   C. Calculation:
   - Change in Per Capita Income of 1.0644 x Change in the District's Population of 1.0028 = 1.0674 (multiplier)
   - Last Year's Limit of $11,449,782.00 x 1.0674 (multiplier) = FY2026 Appropriation Limit of $12,221,497.

List of Attachments:

- Draft Resolution 2025 - 08

ECHD RESOLUTION 2025 - 08

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HEALTHCARE DISTRICT ESTABLISHING THE APPPROPRIATIONS LIMIT FOR FISCAL YEAR 2025 -26 IN ACCORDANCE WITH ARTICLE XIIIB OF THE CONSTITUTION OF THE STATE OF CALIFORNIA

WHEREAS, El Camino Healthcare District ("District") has completed its budget analysis and preparation for fiscal year 2026 (July 1, 2025 – June 30, 2026) and, pursuant to Article XIIIB of the California Constitution and SS7900 et seq of the California Government Code, has computed its appropriations limit for such fiscal year; and

WHEREAS, S7910 requires the District to establish by resolution its appropriations limit for the upcoming fiscal year; and

WHEREAS, Article XIIIB S8 (e)(2) directs the District to select its change in the cost of living annually by using either of the following two measurements and to record the vote of the District Board in making this choice:

a) the percentage change in California per capita personal income from the preceding year, or
b) the percentage change in the local assessment roll from the preceding year for the District due to the addition of local nonresidential new construction; and

WHEREAS, Article XIII S8 (f) and S790 (b) directs the District to select its change in the population annually by using either of the following two measurement(s) and to record the vote of the District Board in making this choice:

a) change in population within the District, or
b) change in population within Santa Clara County

NOW, THEREFORE BE IT RESOLVED that:

1. For fiscal year 2026, the District hereby elects to use the following measurement to calculate the District's change in the cost of living:

The percentage change in the California per capita personal income from the preceding year (**6.44**%).

2. For fiscal year 2026, the District hereby elects to use the following measurement to calculate the change in population:

The change in population within the District of **0.0028%.**

3. The Secretary of the District is hereby directed to include in the minutes a record of the vote of each member of the District Board as to the choices set forth in paragraphs 1 and 2.

4. For fiscal year 2026, the District's total annual appropriations subject to limitation are **$12,221,497** calculated as follows.

   a. 1.0644 x 1.0028 = 1.0674 (multiplier)
   b. 1.0674 x $11,449,782 (FY2025 limit) = $12,221,497

5. As required by Article XIIIB S1, the District's total annual appropriations subject to limitation for fiscal year 2025 should not exceed the District's appropriations limit for fiscal year 2026.

   DULY PASSED AND ADOPTED at a Regular Meeting held on the 17th day of June 2025 by the following votes:

   AYES:

   NOES:

   ABSENT:

   ABSTAIN:

_____

John Zoglin, Secretary
El Camino Healthcare District Board of Directors

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING MEMO

To: El Camino Healthcare District Board of Directors
From: Ken King, CAO
Date: June 17, 2025
Subject: FY-2023 District Capital Outlay Fund Request

Purpose: The purpose of this item is to gain approval to use the FY-2023 District Capital Outlay Funds to support the Mountain View Campus, Women's Hospital Expansion.

Summary:

1. Situation: The El Camino Healthcare District has $13,045,226 of Capital Outlay Funds from fiscal year 2023 that must be allocated for use within a two-year period. Note that expenditure from the Capital Outlay Fund must be for a capital land/building project or equipment that has a cost of greater than $100,000 and a useful life of 10 years or more.

2. Authority: The El Camino Healthcare District Board is required to allocate these funds for a qualifying capital project.

3. Background: The District Board approved the Women's Hospital Expansion Project expenditure of $149 million in February 2021. Additionally, the District Board previously allocated $41,789,503 in Capital Outlay Funds to support the funding of the Women's Hospital Expansion project. The project is currently in the 3rd and final phase of the project. Phase 1 was completed and occupied in October of 2023. Phase 2 was completed and occupied in May of 2025. The additional 2023 Capital Outlay Funds of $13,045,226 would bring the total funding support for the Women's Expansion Project to $54,834,729. The remaining funding source for the project comes from the Hospitals operating cash flow. Note that the Capital Outlay Funds are a source of funding only, they do not increase the previously approved project budget.

4. Assessment: For reference see below how the El Camino Healthcare District Capital Outlay Funds have been allocated since FY 2014.

2014	4,145,422	9,297,651	June-16	Women's Hospital Expansion
2015	5,152,229			
2016	6,174,291	6,174,291	June-18	Women's Hospital Expansion
2017	6,958,521	6,958,521	June-19	Women's Hospital Expansion
2018	7,830,671	7,830,671	June-19	Women's Hospital Expansion
	Total	**30,261,134**		
2019	8,988,967	8,988,967	June-21	Campus Completion Project
2020	9,705,831	9,705,831	June-22	Campus Completion Project
2021	11,128,800	11,128,800	June-23	Campus Completion Project
	Total	**29,823,598**		
2022	11,528,369	11,528,369	June-24	Women's Hospital Expansion
Recommended				
2023	13,045,226	13,045,226	June-25	Women's Hospital Expansion

5. Other Reviews: The Executive Capital Committee has reviewed this item and recommends that the FY-2023 Capital Outlay Funds totaling $13,045,226 be allocated to the MV Campus Women's Expansion Project. This will bring the total Fund for the MV Campus Women's Expansion Project to $54,834,729.

6. Outcomes: The District Capital Outlay funds can only be used for the "qualifying elements" of the project that are outlined in the Public Contract Code. These qualifying elements include the design and construction management services, permits and inspections as well as construction so long as it's publicly noticed and publicly bid.

EL CAMINO HEALTHCARE DISTRICT
BOARD MEETING COVER MEMO

To: El Camino Healthcare District Board of Directors
From: George Ting, MD, Board Chair
Date: June 17, 2025
Subject: Board Officer Elections

Recommendation(s):

To elect _____ as ECHD Board Chair for a term of two years effective July 1, 2025.

To elect _____ as ECHD Board Vice Chair for a term of two years effective July 1, 2025.

To elect _____ as ECHD Board Secretary/Treasurer for a term of two years effective July 1, 2025.

Summary:

1. Situation: The current Board Officer terms expire on June 30, 2025.

2. Authority: Pursuant to Article III, Section 4 of the El Camino Healthcare District Bylaws, before July 1st of every odd-numbered year, the District Board shall elect officers from District Directors then in office by majority vote.

3. Background: It has been the Board's practice over the last several years to elect its Board Officers through nominations from the floor at the meeting when the election is held or declaring their interest in serving in advance of the meeting. Director George O. Ting and Director John Zoglin have both declared interest in serving as Board Chair. Director Carol A. Somersille has declared interest in serving as Vice Chair.

4. Outcomes: Board Officers for FY26 and FY27 elected.

George O. Ting M.D. Statement for Chair of District Board of Directors (DBOD) 2025-2027

I am running for DBOD Chair again because I feel I have unfinished business, so for now, continuity trumps the good arguments to share and rotate the role. At this point you are familiar with my leadership's good and bad points: I try to find the right balance between good timekeeping during our meetings, yet allow for full discussions when productive; to maintain decorum and professionalism in meetings, but having fun and humor together helps team spirit; to remember my role and responsibility to each of you and your ideas, and make sure we follow up and keep building on the ideas that have some traction, whether it is population health, or potential benefits of leveraging District real estate.

I think we made some important strides together in the past two years:

- At the top of the list, we have continued and improved our Community Benefit Program, with better DB presence at many of the grant site visits. The review and approval process has been successfully streamlined.

- We are committed to enhancing our relationship with the community. Our first newsletter was not our best work. I am grateful to Administration for their increased attention and resources that will allow us to do better. The next newsletter will be better, and I think some of the Administrative support stems from the DB speaking more clearly with one voice.

- Part of this has been due to working better as a team. We still have work to do, but our individual and group work has made a difference. I sense we value the progress we have been making together. In a word (or so), we have developed a better culture for the DB.

- We have had interesting discussions needing further deliberation on matters such as the DB's persistent interest in our real estate holdings.

- We are developing an identity beyond simply being good stewards of our community benefit funds. We have articulated a higher purpose for the DBOD, and until we find the right catch-phrase, "making our community the healthiest in the nation" says it for now. It has driven us to matters of population health, and tackling prediabetes as a starter, which is something we must monitor carefully for its risk/benefit ratio.

What I would like to see, if I have your support:

- The first is continue what we have been doing: Team building, enhancing community relationships, maintaining and improving our current CB programs, being very deliberate about the benefits and risks of new programs such as population health. But there is more.

- I believe our new-found DB purpose statement is important in a number of ways, because it is somewhat different from the purpose of ECH. ECH's operating goal, is to succeed in "the business of healthcare" as well as to "be good by doing good". As Lincoln is purported to have said to his ardent progressive congressman, knowing which direction the north star is does not tell you of the swamps and pitfalls along the way. The business of healthcare always crosses through many dangerous songs of Sirens, as the United Healthcare is one example out of many. The DB purpose is said equally well by "best healthcare in the country" or always "making the patient the primary customer": both allude to quality of healthcare being more important than the business. If ECH is successful as we all hope, there will be many times that the DB will need to be the guiding light to do things the right way: the El Camino Healthcare way.

- In my mind, that is the identity of the DB, which has been somewhat adrift since the remarkable and unselfish decision by prior DBs when they decided to share governance power with appointed HB

members, thereby diluting much of its own identity. This new identity to be a guiding light is necessary for the DB to do great things, and we can start now.

- As I have said *ad nauseum* during Board meetings, the quality of our network physicians (outpatient) is not where we want it to be. In the spirit of better quality as equally important as being successful, I have poked this governance nose into the management tent (somewhat) to put forth a novel plan to improve the competencies of those physicians. I have written a white paper describing how ECHMN can do better, recognizing that is not something a Board member should do, but in this case, I believe needs to be done. I therefore present it as a proposal for management (and the medical staff) to consider, and to reject, modify, or implement as they see fit, and for me to get my hands out of this after presenting it.

- After reading this (attached) the DB can decide if they think it is appropriate to give a thumbs up simply as indication of support. I hope that having that imprimatur will promote acceptance by the ultimate decision makers which are Administration and the Medical Staff Organization.

- Furthermore our efforts to clarify a District real estate strategy has led to the intriguing thought that there may be ways to expand the District balance sheet (more revenue) without adversely affecting ECH's balance sheet. This could increase the options for us to advance community health, either through the current CBP, or allow us to try other avenues.

- Another issue that has been raised but needs more discussion, is the matter of ECH BOD size and composition. Should the ECH BOD remain an even number that does not include the CEO? Although that is a matter for the ECH BOD to ultimately decide, the appointment of non-elected Board members is one of the most important DBOD functions.

I end with an apology for being long-winded. As Lincoln is also purported to have said: "Once I get going I'm too lazy to stop when I should" With this I nonetheless end up asking for your support.

George Ting

Memo to El Camino Healthcare District Board of Directors

Fellow District Board members:

I am submitting this Concept Paper for us to review, as part of the District Board's purpose of "Making our community the healthiest in California" (Dan said "in the world" at the recent Sunnyvale Community dinner, but a less ambitious claim may lend it more credence). My hope is that adding the imprimatur of the ECDB will encourage its acceptance by Administration and the Medical Staff Organization.

I started this paper over a year ago to further elevate ECH's reputation and standing by closing the physician quality gap between ECH and academic medical centers (AMCs). However, improving the ECHMN became more urgent with the difficulty filling its medical president position and stubborn physician quality metrics. The conclusions from the research for my first goal serendipitously is a way to achieve the second: that the methods to close the ECH-AMCs gap would the same as those needed to improve ECHMN as a medical group. That led to this concept paper which I hope will receive enough support from Administration and the Medical Staff Organization to consider piloting a novel project to address some of the ECHMN concerns we have had over the past few years. I acknowledge it is unusual for a Board member to make a concrete proposal rather than broadly advocating for a goal and allow management to figure out the best way to accomplish it.

This paper addresses an important issue for which Administration has not developed a clear strategy in spite of the urgings of the Hospital Board to address it: physician quality and competency. This is distinct from organizational quality which the Board Quality Committee focuses on through its STEEEP approach. I explain this difference in greater detail in the paper.

In recognition of, and respect for the distinct roles of governance and management, I ask the Board to see this as simply a suggestion for management and the medical staff to consider, and to modify and implement if it chooses to, rather than some prescriptive directive. As some of the comments may be less clear for non-clinicians, I have added examples in an appendix to illustrate concepts; the granularity of details is to clarify, not specify.

The essence of the concept is to use those methodologies proven to work in AMCs, and apply them to develop the culture and practice patterns of a high performing physician group. It will be left to management to modify, further define, structure and implement as it sees fit.

George O Ting

In the modern view, boards bear direct responsibility for the hospital's mission to provide quality care. This responsibility cannot be delegated to the medical staff or executive-level administrative and clinical leadership because it is at the very core of the board's fiduciary responsibility.

The Joint Commission Journal on Quality and Patient Safety, 34:4, 2008.

PHYSICIAN QUALITY AND CULTURE AT EL CAMINO HEALTH (ECH)

Ensuring the quality of clinical care is a responsibility shared by hospital administrations and physicians, both governed by the Board of Directors. The hospital administration manages the institutional aspects such as infrastructure, staffing, safety, infection control, regulatory requirements, coordination of services, and patient experiences while the Medical Staff Organization (MSO) oversees physician competencies in diagnoses, treatment and communication. Board quality reports primarily focus on what is under administrative control and leaves medical staff competency issues to the MSO credentialling process and report.

- ECH's existing board quality program has an organization-centered approach defined by the STEEEP processes. Matters of physician clinical competency are delegated to the Medical Staff Organization which reports to the board only through the credentialing and privileging report. It is telling that in board quality discussions more attention is spent on common hospital catheter-related urinary tract infections than in understanding its standardized hospital mortality rate which is the most important metric of hospital and physician quality of care. Efforts to improve ECH mortality rates would require in depth analysis of the complex practice patterns of many interacting physicians, something that is not possible in ECH's current quality assessment system. This underscores the difficulty of gauging physician competency as there are no widely-accepted objective ways to measure it. What is difficult to measure is difficult to monitor or change, and this problem will only become bigger as ECHMN expands further.

- Hospital quality rankings are routinely published, but physicians are harder to rate except by patient review or peer opinion; both are imperfect but used in the absence of better tools. The best method may still be to ask how well someone likes their own doctor. In any discussion of physician quality, however, physician competency must first be clearly defined.

- A good physician is often described as a good listener, thoughtful communicator, empathetic, respectful, and having a good bedside manner. These usually form the basis of physician reviews by their patients. However, every physician knows colleagues with these traits that do not provide high-quality medical care. Patients can be in a safe, well run, and highly regarded hospital such as ECH yet still be uncertain if their particular doctor has good clinical judgment, will make the best clinical decisions based on current evidence-based guidelines (EBGs), or perform complex procedures and treatments according to best practices, as these are not monitored by the quality programs of the hospital or board.

- It is useful then to examine academic medical centers (AMCs) since their primary mission is to produce competent physicians, whether for clinical practice, teaching or research. They have well-established and time-tested methods for teaching, monitoring and guiding physicians.

Academic Medical Center Methods

All AMCs have three essential components in their teaching programs.

1. LEARNING FACTS AND TECHNIQUES. This is the simple part, learning fundamental facts didactically, and procedures and skills through demonstrations and practice. Developing a culture of continuous learning is important as advancements in knowledge and theories demand ongoing critical re-evaluations.

2. LEARNING WHAT TO DO. After accumulating knowledge, the most important competency is learning when and how to apply it in any given situation, as well as the judgment and skill to do it well. When a patient presents with symptoms, it is vital to know what questions need to be asked, and what things need to be done or not done. Over time, clinical judgment is developed through discussions and deliberation.
3. HAVING THE RIGHT ENVIRONMENT AND CULTURE. Sustaining a level of competence over a lifetime depends on working in a culture of learning and accountability. In every AMC, the department chief has the crucial role of maintaining this culture, setting high expectations, and holding physicians accountable for what they do.

As a result of these three elements, a good doctor can be defined as one who:

1. has learned what is needed,
2. has good clinical judgment, makes good decisions on what needs to be done and can do it well,
3. will maintain learning and reliable performance over the long-term.

Other attributes are nice, but the *sine qua non* of a competent physician is knowing what to do and taking those actions at the right time.

Post Training

When a physician enters private practice, there is an abrupt transition from the academic to a non-AMC setting where efficiency and production are prioritized. There are far fewer educational activities and discussions. There is much less oversight or review of one's practice patterns, as each physician is the attending physician. For a young physician, the challenge is to keep learning and maintaining a consistent level of performance for decades. Towards this, the environment and culture are critical factors, and notably, those of a hospital are very different from those of an outpatient practice.

- Hospitals have rigorous quality metrics and programs due to the acute nature of more serious conditions, extensive written policies and procedures, regulatory oversight, and in addition, there is the constant interaction and scrutiny by colleagues, nurses and other professionals. A new physician starting in a hospital culture has an easier time continuing to learn and practice at a high level. ECH has a culture supporting high quality hospital care that has been developed over decades through its proximity to a world class AMC and the high expectations of colleagues and a well-informed community.

- A physician joining an outpatient practice such as ECHMN experiences a culture that is vastly different from that of an AMC. Outpatient practices have less robust quality programs due to the lower acuity of care, less aggressive treatment options, and limited review and regulatory oversight. Physicians work more independently, and this contributes to much wider variations in practice patterns. Most communication is focused on administrative details and the business of healthcare. Without a strong culture prioritizing learning and quality care, tasks and schedules define the culture.

- El Camino Hospital has developed an excellent reputation up to this point. A relevant question is why has this become a problem now? Much of the credit goes to previous nursing leadership which emphasized the importance of compassionate personalized care which is readily apparent. Good doctors from good medical schools chose to practice here and developed the hospital's culture of excellence. Over time outpatient physicians felt confident referring their patients for inpatient specialty care. By and large the ECH reputation reflected the great care from the nurses and inpatient physicians rather than the outpatient referring base.

- Now as ECH includes the outpatient network, the quality of primary care is in the spotlight, and therein lies a problem. Managing outpatient care is difficult at best, especially for a hospital-centric organization

with little experience managing primary care. Six years into our medical network operations, much good work has been done with operations and growth, but the Board must look at ways it can promote outpatient physician competency.

- Ironically, good primary care, which can make the biggest differences in long-term health, is in the department with the greatest practice variation, especially among more senior physicians. Its breadth of responsibilities is the widest in medicine, with ever-increasing new screening and prevention options, and better and more complex outpatient therapies for chronic conditions. Yet its functions are also the most difficult to standardize or measure since linking physician competency to long-term outcomes is impractical, as consequential lifestyle choices fall outside physician control. Implementation of EBGs may benefit primary care the most, not because their care is the most complex, but because it is the broadest, covering every specialty, has the most moving parts and thus is the most improved by regimentation.

- In medicine it is one thing to know what should be done; it is another to do it consistently. No one monitors a physician's every action, and no physician is perfect. The sense of responsibility and duty to always do the right thing is deeply influenced by the expectations of the team's culture. It is insidiously demoralizing when primary care activities are not done well yet there are no consequences. It is detrimental to the organization and quality inevitably declines. Some degree of accountability with constructive feedback for errant actions is necessary to maintain a true culture of excellence.

If the best measure of a competent physician is knowing what to do, there are very limited options to improve competency once out of training. One option is to monitor or test for the required knowledge and if considered deficient, then have the information reviewed. The second option is to continually have formal review and discussion of necessary information among colleagues so all are equally informed, then select the EBGs together to standardize clinical practice. This in fact is what is done at AMCs, where competency is achieved through review, discussions, understanding and developing consensus, not through testing or grading.

CONSIDERATIONS FOR ECH

The concepts in this paper are offered to ECH Administration and the Medical Staff Organization (MSO) and to the ECHMN to consider whether to develop such a Physician Quality and Culture.

ECHMN is a recent assemblage of several subgroups that are not yet well integrated nor share a common culture, and none has a physician quality program. Despite many years, its primary metric, the net promoter score, remains below expectations. The hope that one strong medical president will single-handedly transform ECHMN is not realistic and has risks that can be minimized. ECHMN needs a robust physician quality program now as well as a capable medical president. This proposed PQP would be a durable framework through which physician competency can be defined, and which will evolve as medical standards of care progress. This will be an ambitious endeavor as there are no non-AMC systems known to be formally using such an approach and may best be started as a pilot project, and based on the following principles:

- The adaptation of established AMC processes to be the foundation of a Physician Quality and Culture program,
  - Regular education with colleagues to establish communal evidence-based guidelines to decrease unwarranted practice variation,
  - Create and foster a deep culture competency, learning, collegiality and constructive accountability.

- The traditional role of the division chief in an AMC be filled by the ECH medical directors of service lines, or outpatient medical directors of their respective divisions.
- In order to be accepted by physicians, all medical aspects must be led by clinically active physicians with strong administrative support

It is neither difficult nor complex and uses methods all physicians are familiar with from their training, but will require developing new ways to collaborate among the physicians, management and the board. Being part of a high performing medical group counters physician burnout and improves professional satisfaction. The most far-reaching benefit is directly in line with our mission: the best possible long-term health outcomes for our patients, but much more immediate will be better patient experiences and patient satisfaction with El Camino Health.

The concepts presented above may not be intuitively clear to non-clinicians. An appendix is attached to make the concepts more concrete. The details are strictly to promote understanding, and not to be a recipe or directions on how management may choose to proceed. Acceptance and implementation of the principles and operational procedures will be entirely in the hands of Administration and appropriate physicians. For inpatients, they will be all members of the MSO; for outpatients the members of ECHMN.

APPENDIX: Examples for clarification only

To repeat the critical success factors:

1. This must be led by clinically active physicians
    a. Respected leaders organizing and developing all the guidelines with their colleagues will make the program their own, have credible analyses and have acceptable and appropriate accountability.
2. Proper compensation or mandate for departmental physicians to attend meetings.
    a. The carrot is likely to be more effective, and promote more enthusiasm
3. Have adequate administrative support.
    a. Physicians will know what needs to be done, but those in active practice will not be able to record, implement or track results. They will need administrative help to analyze findings and support follow-up actions.

EXAMPLES OF ONE INPATIENT AND ONE OUTPATIENT DIVISION

This proposal can be piloted in two pivotal departments, one primarily in the hospital, and one primarily in the outpatient clinic.

- For inpatient care, management of chronic obstructive pulmonary disease (COPD) has been recommended to be the pilot project. It is one of the CMS 30-day all-cause, risk-adjusted mortality measures required of all acute care hospitals and contributes 22% to CMS Overall Star Ratings, and one in which we have most difficulty.
    - The pulmonary medical director (MDD) will distill the current published EBGs from organizations such as the American Thoracic Society (ATS), American Lung Association (ALA), American College of Chest Physicians (AACP), Society of Critical Care Medicine (SCCM), and Critical Care Societies Collaborative (CCSC), then have periodic meetings with all inpatient and ECHMN outpatient pulmonologist and intensivists to review and tailor the guidelines for use throughout ECH and be used through EPIC.

        - In the future, improving our COPD mortality index will be possible as we can analyze whether it is the EBGs that need to be strengthened, or if it is a matter of inadequate physician adherence to the EBGs.
    - In this division, how to monitor physician adherence to the EBGs and whether or how to give feedback will be left to the division.

- For outpatient care, standardization of primary care activities could be the pilot project. The primary care physician (PCP) is usually the public's first encounter with ECH, is crucial for overall long-term patient health outcomes and would derive the most benefit from standardization of practice patterns. If done well, this PQP will improve patient outcomes, satisfaction and retention. Mastery of the PCP roles and responsibilities can be the key to elevating perceptions of ECHMN.
    - The primary care MDD will:
        - distill the recommended guidelines from major primary care organizations such as the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), Primary Care Associations (PCAs) and the North American Primary Care Research Group (NAPCRG) for ECH use.
        - have periodic meetings with all ECHMN primary care physicians to review these guidelines and develop the consensus guidelines to be used by every PCP through EPIC.

    - There are two major components to primary care: Screening and Prevention, and Treatment of Chronic Conditions.
        - For screening and prevention, EBGs will specify which procedures, such as vaccinations, are appropriate for which age and risk group, as well as frequency and how to follow up on results. Adherence can be tracked through EPIC.
        - For the very important treatments of chronic conditions, EBGs will specify roles and responsibilities between PCPs and specialists, establish optimal targets for treatment outcomes, and thresholds for referrals if targets are not met.
            - Treatment targets will be guided by best evidence and usually be more aggressive than what is reported to CMS (through HEDIS, or Healthcare Effectiveness Data and Information Set, which represents minimum rather than optimum standards).
                - Achieving optimal standards where possible can result in significantly better long-term outcomes.
            - Coordination of care for discharged patients with certain diagnoses should be included in the EBGs for inpatient and outpatient care. As an example, when the patient with AMI is discharged from the hospital, there will be specific instructions on when the patient needs to be seen in the clinic, whether by the PCP or the outpatient cardiologist first, and how to modify and continue the guidelines started in the hospital.

    - In this division, physician adherence to the EBG should be monitored. Monitoring adherence to the EBG will standardize the care and promote a specific culture which focuses on long-term outcomes. How feedback to physicians will be done will be left to the division.

Dear Esteemed Members of the El Camino Healthcare District Board,

I am writing to you today to convey my interest in taking on the role of ECHD Chair for the upcoming term, commencing on 7/1/25. My candidacy may be considered attractive along two parameters – temporal and experiential.

Traditionally, most locally elected boards, without a publicly elected leader eg Mayor or Chair, choose to rotate their top leadership position among members. Such an approach reflects a commitment to shared governance which contributes to ensuring diverse leadership perspectives and priorities. I have served on the ECHD board for a decade while stepping back to allow others to serve as Chair.

As chair of ECHD board I led our efforts to modernize our governance structure that has allowed us to provide quality governance and oversight of El Camino Health as it has trebled its revenue (since I joined as an ECHD board member) and significantly increased the quality of care delivered to our community. I also contributed to improving administrative details that support meeting transparency and efficiency, such as adding expected time-frames for agenda items.

Having served for 18+ years I possess a depth of institutional knowledge and leadership experience that is well-suited to this position. My past roles have equipped me with a keen understanding of our mission, the challenges we face, and the strategies that drive us forward. I am confident that my experience can provide both the practical background and strategic vision necessary to navigate the future of the El Camino Healthcare District.

Thank you for considering my application.

Sincerely,

John Zoglin
Director

Carol A. Somersille, MD, FACOG
Position Statement for Vice Chair, El Camino Healthcare District Board

Dear Fellow El Camino Healthcare District Board Members:

I hereby request your consideration for reelection as Vice Chair of the El Camino Healthcare District Board.

It has been a joy to work alongside you, who are so dedicated to helping our healthcare district residents achieve maximal attainable wellness. We make an excellent team, each with different yet complimentary strengths. As Vice Chair, I have acknowledged and encouraged use of those strengths in support of an effective, cohesive board.

As we grow and complete our strategic goals, attention to healthcare quality, patient safety, and community wellness is essential.

For the past two years I have been Chair of the Quality, Patient Care, and Patient Experience hospital board committee. As such, I have ensured that El Camino Hospital Board places quality of care tantamount when discussing our goals. I encourage community expert committee members to provide guidance and valuable insight. This has led to improved outcomes.

At my suggestion, we now convene organizations that tackle similar healthcare problems in order to pool expert opinions, decrease duplication, and improve outcomes. Traditionally, we used the Community Needs Assessment to evaluate healthcare district resident needs. However, our residents are unique and I requested more granular data which led to the hiring of a population health manager. This led to a pilot program to isolate a high impact disease, focus on that disease, and lower the incidence. We are currently in the fact-finding stage and receiving input from our community partners. Through these efforts, we are increasingly recognized a valuable leader.

I am grateful for having had the opportunity to serve as Vice Chair, El Camino Healthcare District Board. My experience in this role, clear sense of our purpose, dedication, and ability to foster collaborative relationships best equip me to continue in this role. Thank you for your consideration.

EL CAMINO HEALTHCARE DISTRICT BOARD OFFICERS

FY2008 to Present

Year	Board Chair	Vice Chair	Secretary/Treasurer
FY26 – FY27			
FY24 – FY25	George Ting, MD	Carol A. Somersille, MD	John Zoglin
FY22 – FY23	Julia Miller	Peter Fung, MD	Carol A. Somersille, MD
FY20 – FY21	Gary Kalbach	George Ting, MD	Julia Miller
FY18 – FY19	Peter C. Fung, MD	Julia Miller	John Zoglin
FY16 – FY17	Peter C. Fung, MD	Dennis Chiu	Julia Miller
FY14 – FY15	Patricia Einarson	Julia Miller	Dennis Chiu
FY12 – FY13	John Zoglin	Uwe Kladde	Patricia Einarson
FY10 – FY11	Wes Alles	John Zoglin	Uwe Kladde
FY08 – FY09	Dave Reeder	Wes Alles	John Zoglin

Implementation Strategy Report and Community Benefit Plan, FY 2026

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II. ABOUT EL CAMINO HEALTHCARE DISTRICT

El Camino Healthcare District was formed to provide healthcare services that foster good physical and mental health. The District is governed by a five-member publicly elected Board and provides oversight of El Camino Health. The District also administers a Community Benefit Program, which addresses unmet health needs through grants and collaborations with local schools, nonprofits, and social and health service providers.

MISSION

The mission of the El Camino Healthcare District shall be to establish, maintain and operate, or provide assistance in the operation of one or more health facilities (as that term is defined in the California Health and Safety Code Section 1250) or health services at any location within or without the territorial limits of the District, for the benefit of the District and the people served by the District, and to undertake any and all other acts necessary to carry out the provisions of the District's Bylaws and the Local Health Care District Law.

COMMUNITY BENEFIT PROGRAM

El Camino Healthcare District utilized El Camino Health's Community Health Needs Assessment (CHNA) as a framework for Community Benefit funding. The CHNA is developed in compliance with IRS requirements. The District invests in programs addressing the identified health needs for community members who live, work or go to school in the District's boundaries. El Camino Healthcare District cities include most of Mountain View, Los Altos and Los Altos Hills; a large portion of Sunnyvale; and small sections of Cupertino, Santa Clara and Palo Alto.

El Camino Healthcare District, in partnership with El Camino Health, provides funding through the Community Benefit Program in the form of grants and sponsorships to organizations that demonstrate an ability to impact the health needs of vulnerable, underserved and at-risk community members.

Every year, the Community Benefit Annual Report informs the community about Community Benefit Program financials, the grant programs and how these funded services improve the health of vulnerable populations both through direct services and prevention initiatives.[a]

[a] https://www.elcaminohealth.org/about-us/community-benefit

III. PURPOSE OF IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

This Implementation Strategy Report (IS Report) and Community Benefit Plan (CB Plan) describes El Camino Healthcare Districts's planned response to the needs identified through the 2025 CHNA process.

This 2026 IS Report and CB Plan is based on the 2025 CHNA and outlines El Camino Healthcare District's funding for fiscal year 2026. It will be updated annually based on the most recently conducted CHNA.

Financial Summary

FY2026 El Camino Healthcare District Community Benefit Plan:

- 59 Grants: $8,413,000
  - Requested Grant Funding: $10,455,762
- Sponsorships: $90,000
- Placeholder: $497,000
- Plan Total: $9,000,000

IV. LIST OF COMMUNITY HEALTH NEEDS IDENTIFIED IN THE 2025 CHNA

The 2025 CHNA assessed community health needs by gathering input from persons representing the broad interests of the community. This primary qualitative input was used to determine the community's priorities. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes, health disparities, and health trends. Statistical data were compiled and compared against statewide rates and averages.

To be considered a health need for the purposes of the 2025 CHNA, the need had to fit a standard definition, be present in at least two data sources, and either prioritized by key informants or focus groups, or suggested by direct statistical indicators that fail benchmarks or exhibit documented inequities by race.[b] A total of 14 health needs were identified in the 2025 CHNA. The health need selection process is described in Section VI of this report.

2025 Community Health Needs List

1. Housing
2. Economic Stability
3. Behavioral Health
4. Diabetes & Obesity
5. Respiratory Health
6. Unintended Injuries/Accidents
7. Healthcare Access & Delivery
8. Heart Disease & Stroke
9. Maternal & Infant Health
10. Education
11. Cancer
12. Communicable Diseases
13. Community Safety
14. Sexual Health

[b] The definition of a health need is a poor health outcome and its health driver, or a health driver associated with a poor health outcome that has not yet arisen as a need. Further definitions of terms and specific criteria for health needs identification may be found in El Camino Health's 2025 CHNA report.

V. THOSE INVOLVED IN THE IMPLEMENTATION STRATEGY (IS) & COMMUNITY BENEFIT PLAN DEVELOPMENT

El Camino Health selected the health needs to address. Actionable Insights, LLC, provided guidance and expertise for this process and conducted research on evidence-based and promising practices for each selected health initiative. Actionable Insights is a consulting firm whose principals have experience conducting CHNAs and providing expertise on implementation strategy development and IRS reporting for hospitals.

VI. HEALTH NEEDS THAT EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

In October 2024, the Hospital Community Benefit Committee (HCBC) met to review the information collected for the 2025 CHNA. The purpose of the meeting was to help select the needs El Camino Health would address, which would form the basis for its FY2026 community benefit plan and implementation strategies. The HCBC, by consensus, selected the following needs to address:

- Healthcare Access & Delivery (including oral health)
- Behavioral Health (including domestic violence and trauma)
- Diabetes & Obesity
- Other Chronic Conditions (other than Diabetes & Obesity)
- Economic Stability (including food insecurity, housing, and homelessness)

El Camino Healthcare District utilizes El Camino Health's CHNA and selected health needs as a framework for its Community Benefit funding.

DESCRIPTION OF HEALTH NEEDS EL CAMINO HEALTHCARE DISTRICT PLANS TO ADDRESS

Healthcare Access and Delivery (including oral health)

Healthcare Access and Delivery, which affects various other community health needs, was identified as a top health need by two-thirds (67%) of focus groups and key informants combined. CHNA participants highlighted high copays and lack of insurance coverage among community residents (e.g., high deductibles, lapsed coverage among Medi-Cal-eligible individuals) as barriers to healthcare access. Statistical data show that Santa Clara County's proportion of uninsured residents is low, yet it is slightly higher (worse) than San Mateo County's. Many key informants and focus group participants connected healthcare access with economic instability, noting that people are less likely to seek care if they cannot pay for it.

Participants felt there were significant issues with access to preventive care (e.g., colonoscopies, mammograms), including long wait times for such appointments, which could lead to worsened health outcomes. Some professionals specifically noted that the healthcare system is under such strain that some preventable issues become acute due to the consequent long waits for these appointments.

CHNA participants indicated that community-based clinics and programs providing direct healthcare services are beneficial but underfunded. In particular, participants focused on difficulties in accessing dental care, especially for low-income individuals and those on Medi-Cal. They explained that there is a significant lack of providers who actually accept Denti-Cal.

Participants noted that even basic dental care can be prohibitively expensive, leading patients to delay or forego treatment altogether.

Participants said migrant and undocumented communities struggle greatly with access to healthcare due to high costs, lack of insurance, and difficulty navigating the medical system. Many community members have challenges understanding medical terminology and knowing what questions to ask providers. Participants also mentioned access barriers for individuals with disabilities or special needs and those with poor transportation options.

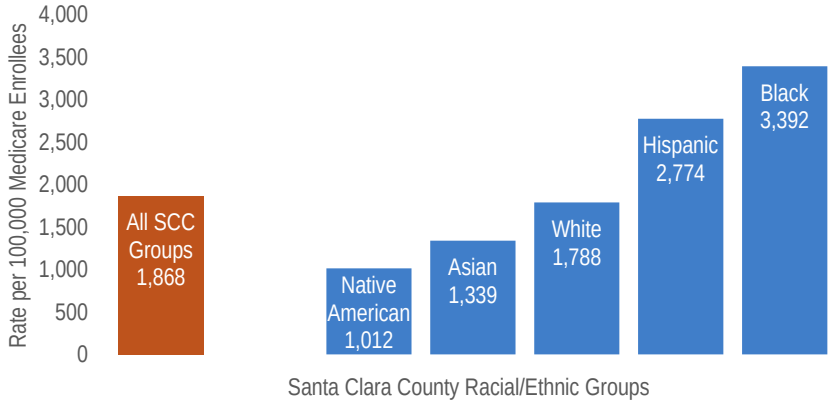
> *“Most nurses or medical practitioners do not know ASL [American Sign Language]... I do not feel good always going with the translator or having to write [things] down or wait longer periods just to be attended to.”*
>
> —Participant, Community Focus Group

CHNA participants described the lack of cultural concordance, or at least cultural competence, as a significant issue in healthcare delivery, with certain populations experiencing discrimination and language barriers that hinder access to care. Close to 9% of the county’s population is not proficient in English. In particular, over 9% of children in Santa Clara County live in a limited English-speaking household, a higher proportion than in neighboring San Mateo County or California overall (both around 7%). In addition to limited English-speaking households, participants also recognized the LGBTQ+ community as a group that faces significant disparities across health indicators. One local expert noted that stigmas and historical mistreatment make it difficult to gather data on the LGBTQ+ population’s specific needs.

> *“I'm seeing folks who are not aware of resources, if they're aware of resources they don't know how to access, or they have apprehensive thoughts or actions about accessing those resources for a variety of reasons."*
>
> — Service Provider, Health Equity Focus Group

CHNA participants described systemic inequalities resulting in higher rates of chronic illnesses and lower quality of care for Black, Indigenous, and people of color (BIPOC) groups. For example, preventable hospital stays, which are higher among Black and Hispanic populations compared to Whites and Asians in Santa Clara County, may be a sign of inequitable access to high-quality care.

Black and Hispanic Medicare enrollees have significantly higher rates of preventable hospital stays than other groups.



Source: Center for Medicare & Medicaid Services Mapping Medicare Disparities Tool, 2020. Retrieved from County Health Rankings, June 2024.

Several CHNA participants specifically mentioned inequities in care provided to Black people, including inadequate maternal care. Access to critical maternal health services, including perinatal care, was a recurring issue among participants consulted during the CHNA as well. Certain maternal and infant health statistics are worse in East San José than in the county overall, including the proportion of premature births, low birthweight births, and infant mortality. Infant mortality and pre-term births in Santa Clara County are highest for Black and Hispanic babies. The county's low birthweight babies are disproportionately born to Black mothers. Teen births are highest among the county's Latinas (16 per 1,000 females aged 15-19) compared to their peers of other ethnicities (most fewer than 6 per 1,000).[c] Of all teen births, nearly 84% are to Santa Clara County Latinas. Maternal morbidity in Santa Clara County is highest among the Black population (193.9 per 10,000 delivery hospitalizations) compared to the overall rate (136.7 per 10,000), including issues such as preeclampsia, hypertension at delivery, and postpartum depression.[c] Young mothers and mothers of color who participated in the CHNA reported feeling judged and stereotyped by healthcare providers, which affected their general care experience and the quality of the care they received.

CHNA participants also spoke at length about issues of access to mental healthcare and substance use treatment, which is covered in the Behavioral Health need description, below.

Behavioral Health (including domestic violence and trauma)

Behavioral Health, which includes mental health and trauma as well as consequences such as substance use and domestic violence, ranked high as a health need, being prioritized by more than three-quarters (77%) of the CHNA's focus groups and key informants combined.

CHNA participants frequently noted increases in feelings of loneliness and isolation among community members of all ages, including older adults and youth. Participants emphasized that

[c] Rates are not age-adjusted.

isolation and loneliness among older adults has worsened since the COVID-19 pandemic, exacerbating mental health issues. One expert highlighted the connection between loneliness, lack of social engagement, and cognitive decline in geriatric populations. Participants also expressed great concern regarding youth mental health. They mentioned high levels of anxiety and depression among youth and young adults, with particular emphasis on students of color and English language learners. Based on public health statistics, mental diseases/disorders are the primary reason for child hospitalizations in Santa Clara County.

Many participants suggested that economic stressors and structural inequities, such as those created by systemic discrimination, have heightened poor mental health overall. One of the common barriers identified was insufficient support systems. In particular, postpartum depression and anxiety were common issues among participants who were mothers, with many feeling they did not receive adequate mental health support.

Mental healthcare access is somewhat worse overall in Santa Clara County than in San Mateo County, and especially poor for youth: there are far more students per school psychologist in the county (1199:1) compared to the state ratio (1041:1) or that of San Mateo County (994:1). Specific populations that CHNA participants identified as disproportionately affected by access to mental/behavioral healthcare included the unhoused, rural, and limited-mobility populations, who have issues with physical access; low- and middle-income populations, whose challenges are primarily economic access; and English learners, people of color (Asian and Pacific Islander, Black, and Hispanic populations), and LGBTQ+ populations, who experience care delivery issues including linguistic and cultural mismatches. Concerns also arose over low utilization related to the stigma of poor mental health among low-income communities and Asian and Pacific Islander communities, to name a few.

There are also geographic differences to consider. Although self-harm hospitalizations are not worse for the county overall (27.2 per 100,000 population) compared to state or local benchmarks, the rate is significantly higher in the Mountain View area (32.9). Similarly, while Santa Clara County's overall suicide rate (7.7 per 100,000) is not as high as the state rate, the suicide rate in East San José (8.4) surpasses the county's rate. Overall, deaths of despair (deaths due to alcohol, drug use, or suicide) are also higher in East San José (44.8 per 100,000) compared to the county overall (30.8).

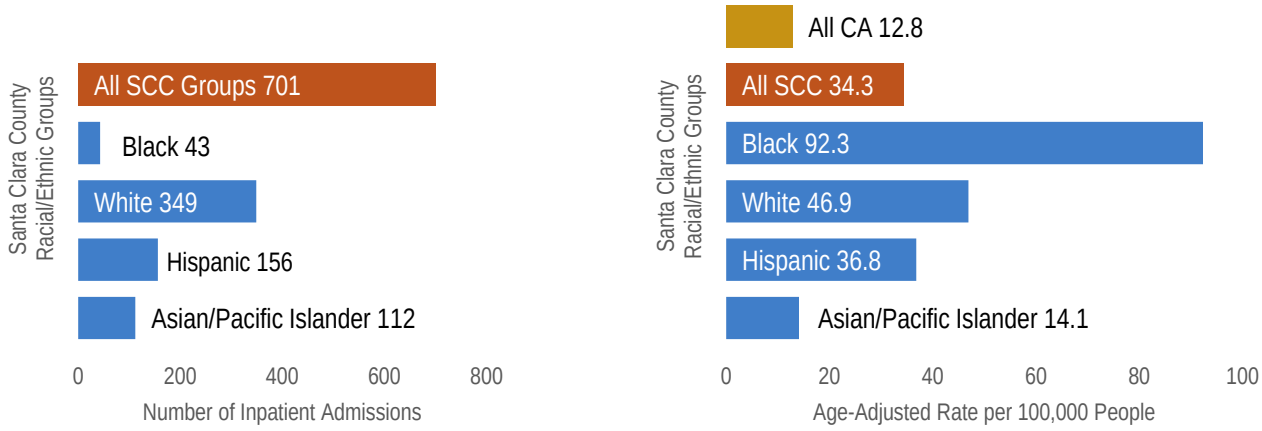
> *"You have individual trauma, you have community trauma, familial, you have generational trauma. … I also think addiction thrives in isolation and loneliness and disconnection. And when I think about this huge spike we saw of overdose deaths being driven by fentanyl and methamphetamines, I think that is a huge part of it as well. It [the combination of issues] makes it hard for folks, even when they're seeking treatment, to stay healthy and well."*
>
> —Behavioral Health Expert

Trauma was frequently cited as a root cause of substance use, mental health issues, and subsequent community violence.

Key informants and focus group attendees spoke about countywide increases in substance use, which they said was often employed as a coping behavior in situations when individuals experience social isolation, high stress, and/or discrimination (e.g., racism). Additionally, participants expressed concern about levels of use of various substances in the county (e.g., higher rates of cannabis and alcohol use among youth and LGBTQ+ populations; greater methamphetamine use among the unhoused and justice-involved populations). They reported that there is a lack of accessible substance use treatment programs (inpatient/residential), and long waiting lists for the few programs that do exist. The rise in drug potency continues to lead to higher levels of accidental fentanyl-related and other opioid-related overdoses and deaths, and was referenced multiple times among CHNA participants. Participants described Santa Clara County's low-income population as being the first in the county affected by rising opioid overdoses, followed by more affluent populations.

Among all ages, opioid overdose hospitalization rates in the county (34.3 per 100,000 people) and, specifically, in the Mountain View area (34.2), are close to triple California's rate (12.8). Although excessive alcohol use is no worse in the county than at the state level, the proportion of driving deaths with alcohol involvement is still higher in Santa Clara County than in neighboring San Mateo County (though trending down). Recent alcohol use by youth (measured as use within the past month) appears to be highest among the county's Black and Pacific Islander populations, compared to their peers of other ethnicities. Santa Clara County's American Indian/Alaskan Native population had the highest proportion of youth across all ethnic groups who tried alcohol more than seven times in their lifetime.[d]

The number of opioid hospitalizations is highest among White residents, but the rate per 100,000 population is highest for Black residents.



Source: California Department of Health Care Access & Information (HCAI), Patient Discharge Data, 2017-21.

[d] Note that of the youth in Santa Clara County's public schools (7th, 9th, 11th, and non-traditional students, aligning with the indicators shown), Black students are 1.9%, Pacific Islander students 0.5%, and Native students 0.2% of all enrolled students in those grades. Therefore, alcohol use proportions should be treated with caution.

Finally, close to two in five focus groups and interviews prioritized community and family safety. Some CHNA participants noted an increase in domestic violence cases following the COVID-19 pandemic, with cases becoming more complex and requiring more individual-level support. Statistics show that domestic violence-related 911 calls are higher in Santa Clara County (4.7 per 1,000 people aged 18–69) than in neighboring San Mateo County (4.0).[e] In addition, the rate of substantiated child abuse/neglect cases in the county is more than double that of San Mateo County. CHNA participants linked family safety concerns to economic instability and housing issues. They noted that financial stress and lack of stable housing contribute to unsafe environments. Participants identified immigrant communities and low-income families as particularly vulnerable to these issues. They said the stress from unsafe environments affects family dynamics and overall well-being.

Diabetes and Obesity

Just over one-third (35%) of key informants and focus group discussions identified Diabetes and Obesity as a top health need. Among discussion participants, there was a shared emphasis on the need for care focused on prevention through education, nutrition support, and lifestyle changes. Likewise, the importance of culturally competent health initiatives was mentioned in this context (i.e., programs that are accessible and relevant to diverse populations). Structural inequities were also seen as fundamental to the origins of diabetes and obesity; for example, some participants discussed the need for continued efforts to improve local food systems in places where diabetes is particularly prevalent.

Economic insecurity and poverty along with the high cost of living were frequently mentioned as underlying factors that exacerbate diabetes and obesity. For example, some indicated that inflation has made it more difficult for low-income families to afford nutritious food and the lack of healthy alternatives diminishes the ability of families to sustain healthy lifestyles.

> *"How do you promote healthy eating when all you have is McDonald's and Taco Bell on every corner? You have liquor stores that sell food, but it's all just processed foods. …I've had diabetics who were homeless, but they could only eat what was given to them. These shelters[,] the food banks… a lot of the times it's just carbs after carbs, or it's canned food. And I mean, I know it's something. But …it's like this terrible cycle. How do we get better nutrition to our community?"*
>
> —Healthcare Provider

Some participants further linked the experience of chronic stress to poor management of diabetes and obesity, highlighting the need for integrated care approaches.

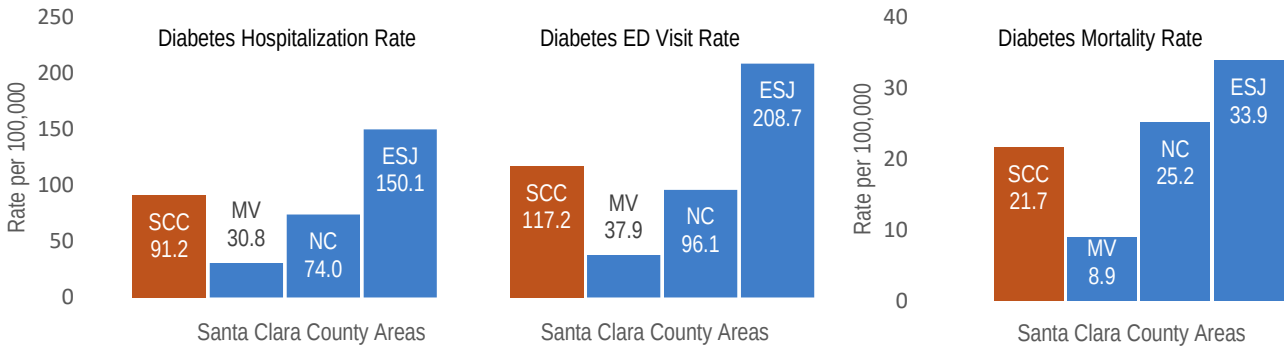
Participants noted that high copays and lack of insurance coverage for effective diabetes medications are significant barriers. They also said that access to nutritionists and proper

[e] Rates are not age-adjusted.

dietary guidance is limited, making it more difficult for patients to manage chronic conditions like diabetes effectively. One participant emphasized the challenge of underdiagnosis of prediabetes among Hispanic community members despite high diabetes rates.

Diabetes mortality is 50% higher in Santa Clara County (21.7 per 100,000) compared to the state rate (14.4). It is highest in East San José (33.9), and also high in the northern part of the county (25.2). Deaths from diabetes are much higher among both the Black (41.0) and Hispanic (37.0) communities in Santa Clara County compared to other ethnic populations in the county. Tracking with the mortality rate, emergency department visit rates and hospitalizations for diabetes are also highest in East San José and among both Black and Hispanic residents of Santa Clara County. The Silicon Valley Latino Report Card states that over 20% of Hispanic children are overweight.[f] Supporting these data, some CHNA participants noted that diabetes is a significant issue in East San José, with high rates of both diabetes and prediabetes, particularly among Hispanic and Asian populations.

Diabetes morbidity and mortality rates (per 100,000) are worse in East San José than Santa Clara County overall and worse than the other sub-county target areas of Mountain View and North County.



Source: Santa Clara County Public Health Department. ED Visits and Hospitalizations are 2017-21; Mortality 219-23. SCC=Santa Clara County; MV=Mountain View Corridor; SC=South County; NC=North County; ESJ=East San José.

While low overall, child diabetes hospitalizations are higher in Santa Clara County compared to San Mateo County. Physical fitness, one of the drivers of diabetes and obesity, is also lower (worse) for elementary and middle-schoolers in Santa Clara County than in San Mateo County. Although high-schoolers appear to be faring better, physical fitness among the county's ninth graders is declining, while Hispanic and Pacific Islander children are performing considerably worse than their peers of other ethnicities when it comes to physical fitness.

None of the other available statistics (e.g., adult physical activity, child diet, food environment, exercise opportunities) are worse for the county overall compared to either neighboring San Mateo County or the state as a whole. However, these state and local benchmarks are not considered particularly healthy. For example, over 20% of Santa Clara County adults are obese, compared to 21% of San Mateo County adults and 30% of CA adults. Similar proportions

[f] Hispanic Foundation of Silicon Valley. (2023). *2023 Silicon Valley Latino Report Card.*

among adults who are physically inactive can also be found in each geography. One CHNA participant noted that physical activity is hindered by safety concerns in certain neighborhoods, making it difficult for residents to exercise freely outdoors, while others mentioned the lack of access to exercise facilities in certain areas.

Chronic Conditions (other than diabetes and obesity)

Santa Clara County generally fares well with respect to chronic conditions other than diabetes and obesity: overall mortality rates for Alzheimer's disease and other dementias, cancer, chronic liver disease/cirrhosis, heart disease, and stroke are all better than state benchmarks. For that reason, most of these chronic conditions were not identified as health needs in the 2025 Community Health Needs Assessment (CHNA). However, health conditions such as cancer, cardiovascular disease, and respiratory problems are among the top 10 causes of death in Santa Clara County.[g] In addition, there are some concerning statistics and data that show significant racial/ethnic disparities for cancer and respiratory conditions. Finally, El Camino Healthcare District has a commitment to continuing to address chronic conditions as a health need, given its specific expertise and long-standing work on this issue.

About one-third (35%) of key informants and focus groups combined named a chronic condition (e.g., cancer, heart disease) as a top health need. Below are the common themes related to chronic conditions that arose during CHNA discussions.

- **Respiratory health:** Some participants described an increase in asthma cases, particularly among children. The importance of a healthy environment and climate was mentioned, with some participants mentioning that climate change and poor air quality can negatively impact respiratory health. Experts participating in the CHNA noted a significant increase in tuberculosis (TB) rates, particularly among individuals who have been in the country for over 10 years. They said the pandemic made this issue worse due to reduced testing and diagnosis.
- **Cancer:** A professional noted that the pandemic led to a decrease in routine screenings like mammograms, which may have resulted in missed or delayed cancer diagnoses. Community members' stories also illustrated potential gaps in timely and comprehensive cancer screening.
- **Cardiovascular health:** Economic instability and poverty were frequently mentioned as factors that limit access to healthy food and healthcare services, which are crucial for preventing and managing heart disease. Some participants also highlighted the high cost of accessing healthcare, including insurance and prescriptions, as a significant barrier to managing cardiovascular health.
- **Alzheimer's disease and dementias:** Many participants highlighted the issue of social isolation among older adults, which plays a factor in cognitive decline and dementias. One professional in particular described long waitlists for nursing facilities and

[g] Silicon Valley Institute for Regional Studies. (2022). *Silicon Valley Indicators.* Deaths, by Cause: Santa Clara and San Mateo Counties.

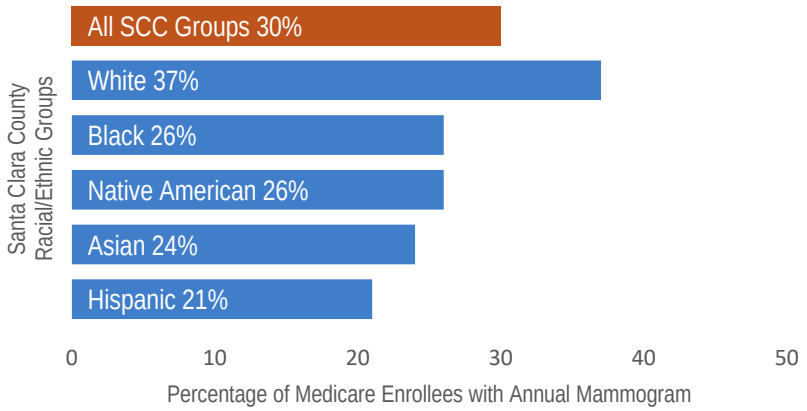
challenges accessing in-home care, made more problematic by the general absence of family support that is often due to the economic migration of younger generations.

"When we're talking about the older adult population that is most likely to develop, say, dementia, there's usually some other kind of chronic condition that goes along with that. It's mainly manageable, but it gets more complicated by the overlay of dementia. So access to care and follow-up care is really important."

— Service Provider

Although Santa Clara County's overall cancer mortality (112.0 per 100,000) is on par or better than the state (119.8), mortality by race/ethnicity indicates substantial disparities. For example, overall cancer mortality among Santa Clara County's Black population is much higher (143.5) compared to other ethnic groups. Similarly, the county's Black population has higher rates of mortality for female breast, colorectal, and prostate cancers. While the county's White population also has cancer incidence and mortality rates that exceed benchmarks, these rates are generally lower than those of the county's Black population. Mammography screening among older adults in the county is highest for White women, and lowest for Latinas.

Hispanic older adults are the least likely to have had a mammogram (breast cancer screening) compared to their peers from other racial/ethnic groups.



Source: Centers for Medicare & Medicaid Services Mapping Medicare Disparities Tool, 2020. Retrieved from County Health Rankings, June 2024.

In addition, some Santa Clara County cancer incidence rates are of marked concern. The county's liver cancer incidence rate is 10.5 per 100,000 people, higher than in neighboring San Mateo County (9.1) or statewide (9.9). The county also has a higher colorectal cancer incidence rate compared to San Mateo County. Finally, Santa Clara County has a higher overall cancer incidence rate for youth aged 15-19 compared to San Mateo County.

Mortality rates for both heart disease and stroke are much higher among the county's Black and Hispanic populations than other ethnic groups. Although Santa Clara County Whites also have a high CVD mortality rate, it is not as high as the rates for certain BIPOC populations.

With regard to respiratory health, Santa Clara County has historically had a higher TB case rate compared to California overall. The most recent data show that TB is still an issue. Asthma is also a concern, especially for children: the overall rate of all Santa Clara County children who were hospitalized for asthma is higher than the asthma hospitalization rate of all children in San Mateo County. However, Santa Clara County children aged 5-17 were hospitalized for asthma at nearly twice the rate (4.0 per 10,000 hospitalizations) of their San Mateo County counterparts (2.1). East San José has disproportionately high child hospitalizations for asthma (5.5 per 10,000 aged 0-17), and the county's Black population has an even higher rate (12.6). Child emergency department visits for asthma are similarly disproportionate.

Given these quantitative and qualitative data, El Camino Healthcare District has grouped cancer, cardiovascular disease, respiratory problems, Alzheimer's and dementia, and other chronic conditions into an overall category that it will address called "Chronic Conditions (other than Diabetes and Obesity)," as indicated above.

El Camino Healthcare District is dedicated to contributing to its community's good health. We will continue to monitor and share these data indicators (and others) to increase awareness of chronic conditions in Santa Clara County.

Economic Stability (including food insecurity, housing, and homelessness)

The vast majority (84%) of all focus groups and key informants identified economic stability and/or housing and homelessness as a top community priority. CHNA participants focused on the high cost of living in Santa Clara County, describing how cost is implicated in interrelated issues:

- Participants said housing market prices remain extremely high, making it difficult for many to afford housing. The data indicate that home ownership is lower in Santa Clara County (56%) than in San Mateo County (60%). Participants described how economic instability forces people to move out of the area or live in overcrowded and/or unsafe conditions (e.g., poorly maintained housing, vehicles, makeshift shelters). Housing quality is still a concern in Santa Clara County; for example, the data show that a small fraction of the county's children and young adults aged 6-20 have very high blood lead levels (at least 9.5 mcg/dL), while San Mateo County has eradicated this issue entirely.

  "We are seeing multi-generational families living in one home. They might not have access to a kitchen. We are seeing a lot of families living in a garage with a microwave."

  "People are cutting costs on their medication, not going to the doctor's, nothing, …and then also living in situations which [are] uninhabitable or not recommended, where there are three families, five families, people are huddled together, couch surfing and sleeping in their cars."

  — Service Providers' Focus Group

- Participants said wages do not keep pace with the cost of living. They explained that low wages and high living costs compel individuals as well as families to make difficult choices between essential needs like food, rent, and healthcare. The data show that the proportion of people experiencing food insecurity in Santa Clara County is higher than in San Mateo County. Participants also indicated that economic insecurity especially affected certain job sectors due to high living costs (e.g., janitorial services). And data show there is a greater gender pay gap in Santa Clara County ($0.73 to the dollar) than there is statewide ($0.86) or in San Mateo County ($0.90).

  "Economic security here is bad. The reason is that the salary is very low. Every time you go to Cárdenas, to any grocery store, the groceries are through the roof. You have to decide whether you eat or pay the rent."

  — Spanish-speaking Community Member

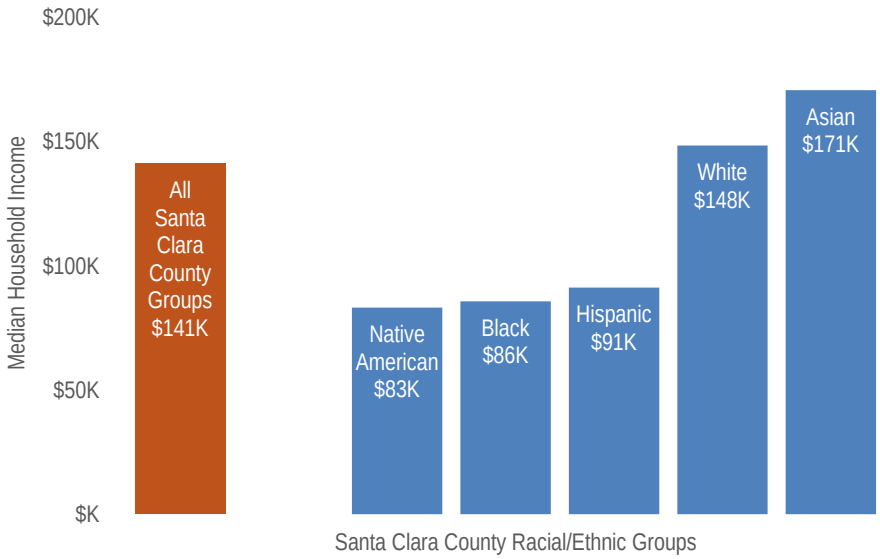
Santa Clara County's percentage of households with children below the Federal Poverty Level is higher than neighboring San Mateo County's, and is rising. In Santa Clara County, Black, Hispanic, and Native American families with children are disproportionately more likely to be in poverty than their Asian or White peers.

The data indicate that childcare costs in Santa Clara County have more than doubled in the past 10 years outpacing median family income, which rose 64% over the same time period. Adequate childcare and preschool were identified by CHNA participants as crucial for economic mobility and foundational learning. Spending per pupil is lower in Santa Clara County ($14,733) compared to San Mateo County ($17,293). Research found that educational inequities, often related to neighborhood segregation[h], lead to educational disparities that begin at an early age.

CHNA participants also identified socioeconomic disadvantages and language barriers as significant inequities affecting educational attainment. Household income inequality by race/ethnicity reached an all-time high in 2022, and there are substantial disparities in median income by race/ethnicity within the county.

[h] Acevedo-Garcia, D., Noelke, C., & McArdle, N. (2020). *The Geography of Child Opportunity: Why Neighborhoods Matter for Equity*. Diversitydatakids.org, Institute for Child, Youth and Family Policy, The Heller School for Social Policy and Management, Brandeis University: Waltham, MA.

Median household income in Santa Clara County varies substantially by race/ethnicity, with BIPOC households earning the least.



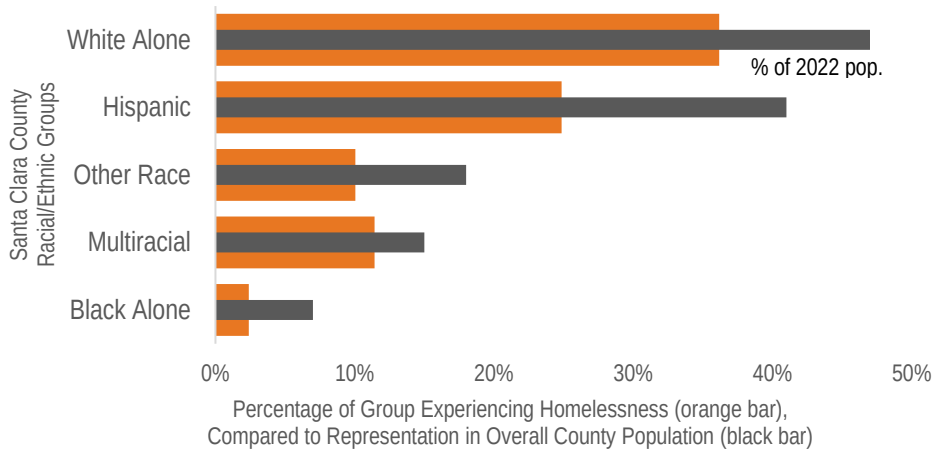
Source: US Census Bureau Small Area Income and Poverty Estimates. Retrieved from County Health Rankings, June 2024.

Santa Clara County's high school graduation rate was lower (83%) than the state rate (88%) in 2022, with the county's Hispanic students more likely than students of other ethnic groups to drop out before graduation. Education has generally and historically correlated directly with income, so educational statistics that differ by race/ethnicity are particularly concerning to CHNA participants.

Specifically with regard to unhoused populations, CHNA participants indicated that mental health issues and substance use disorders can be both causes and consequences of homelessness. Participants also mentioned that parents experiencing homelessness fear losing custody of children because of their unhoused status. Participants enumerated the groups that are most vulnerable to housing instability in Santa Clara County: Black and Hispanic community members, LGBTQ+ community members, single mothers, and foster youth. Black and multiracial people are the most overrepresented in the unhoused population relative to their proportions in the county's overall population. Finally, older adults (aged 65+) and other individuals on fixed incomes can also be vulnerable. Local older adults in Santa Clara County who participated in the Community Assessment Survey of Older Adults give a "Livability Score" of 19 out of 100 for housing.[i]

[i] Polco, formerly the National Research Center. (2023). *Community Assessment Survey for Older Adults: Avenidas, September 2022*.

Among those experiencing homelessness, Black people are the most overrepresented compared to their proportion of Santa Clara County's population.



Source: 2023 Santa Clara County Point-in-Time Count public Tableau dashboard. Population: U.S. Census Bureau. "ACS Demographic and Housing Estimates." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP05, 2022.

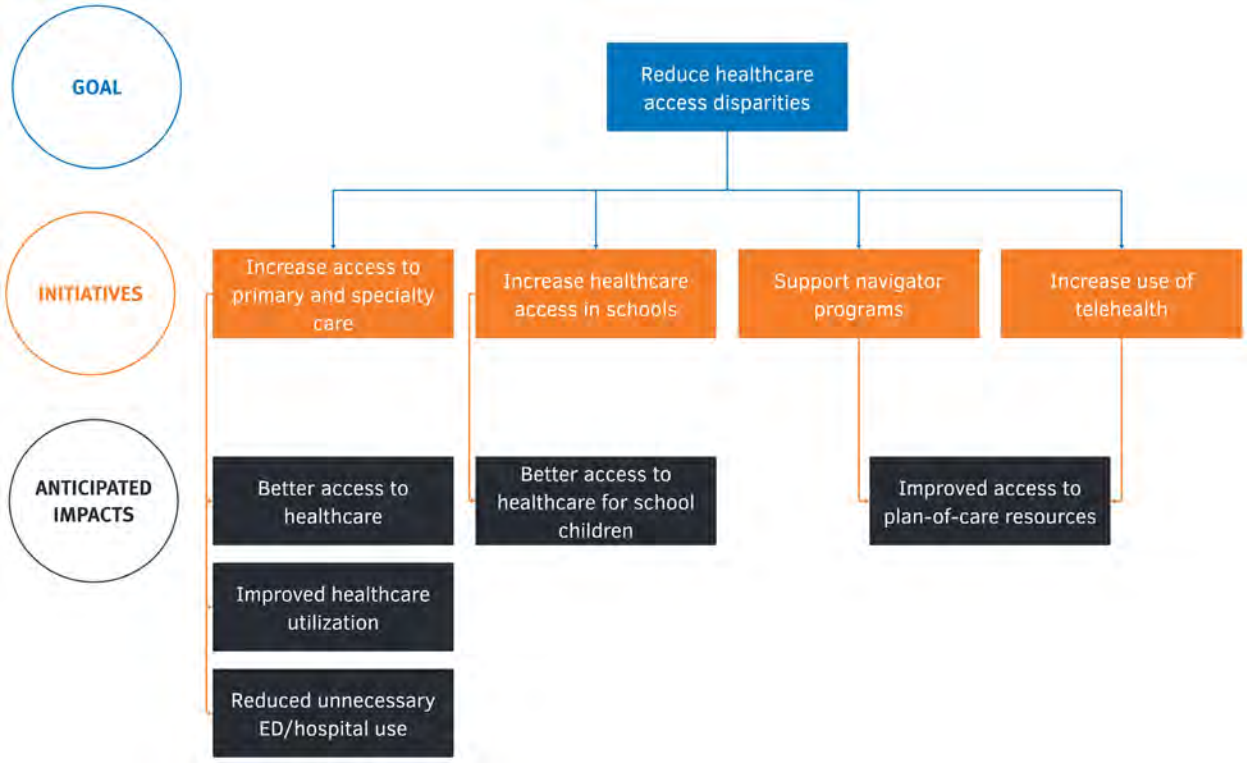
VII. EL CAMINO HEALTHCARE DISTRICT'S IMPLEMENTATION STRATEGY & COMMUNITY BENEFIT PLAN

El Camino Healthcare District's annual community benefit investment focuses on improving the health of our community's most vulnerable populations, including the medically underserved, low-income, and populations affected by health disparities. To accomplish this goal, our community health investment for FY 2026 will be directed to improve healthcare access & delivery (including oral health), behavioral health (including domestic violence and trauma), economic security (including food insecurity, housing, and homelessness), diabetes and obesity, and other chronic conditions (other than diabetes & obesity) through community and hospital-based programs and partnerships.

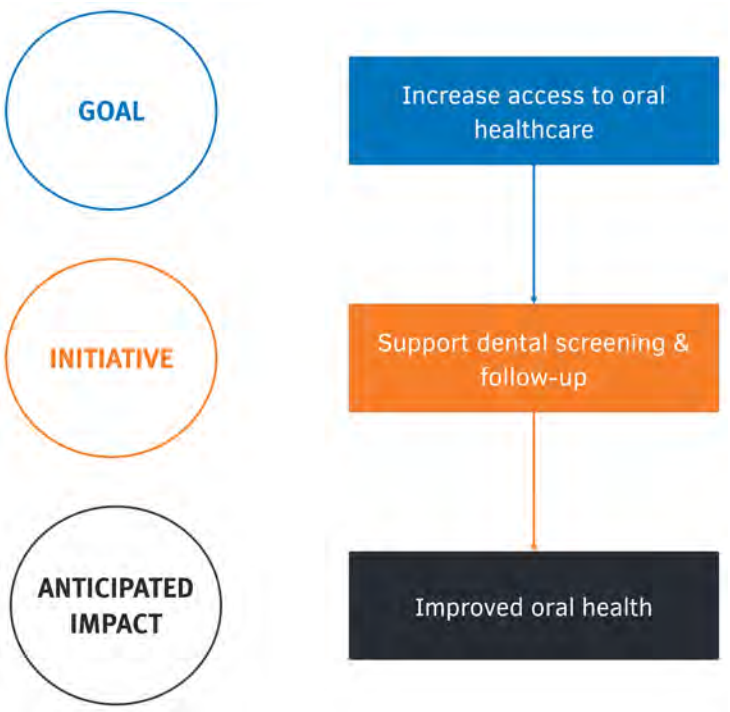
El Camino Healthcare District believes that long-term funding of proven community partners yields greater success than short-term investments in improving the health and well-being of community members. The plan continues to be based on documented community health needs. Modifications to the plan are the result of new data and information collected during the 2025 CHNA process.

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH)

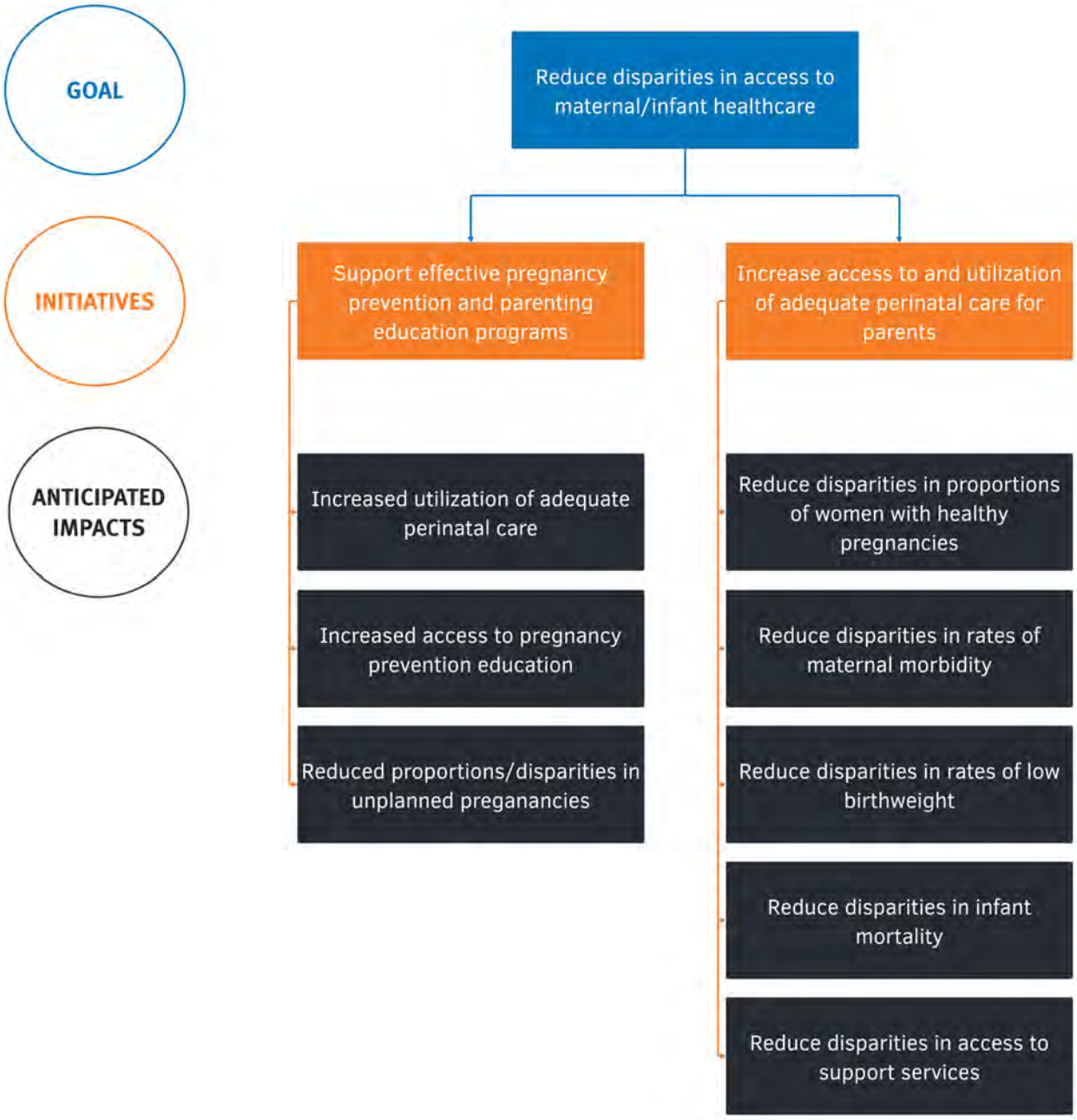
El Camino Healthcare District views efforts to ensure equitable access to high-quality healthcare and respectful, compassionate, culturally competent delivery of healthcare services as a top priority for its community benefit investments. Given the community's identification of issues of healthcare access and delivery during the 2025 CHNA, El Camino Healthcare District selected goals that support initiatives to reduce disparities in access to and delivery of primary and specialty care for community members in its service area. The goals also include improvements in access to and delivery of oral healthcare and maternal/infant healthcare based on statistical data and information provided by experts interviewed during the CHNA. The hospital expects to make a positive impact by improving healthcare access and utilization, reducing unnecessary emergency department visits and hospitalizations, and reducing disparities in health outcomes. Below and on the following pages, see diagrams for summaries and tables for details.



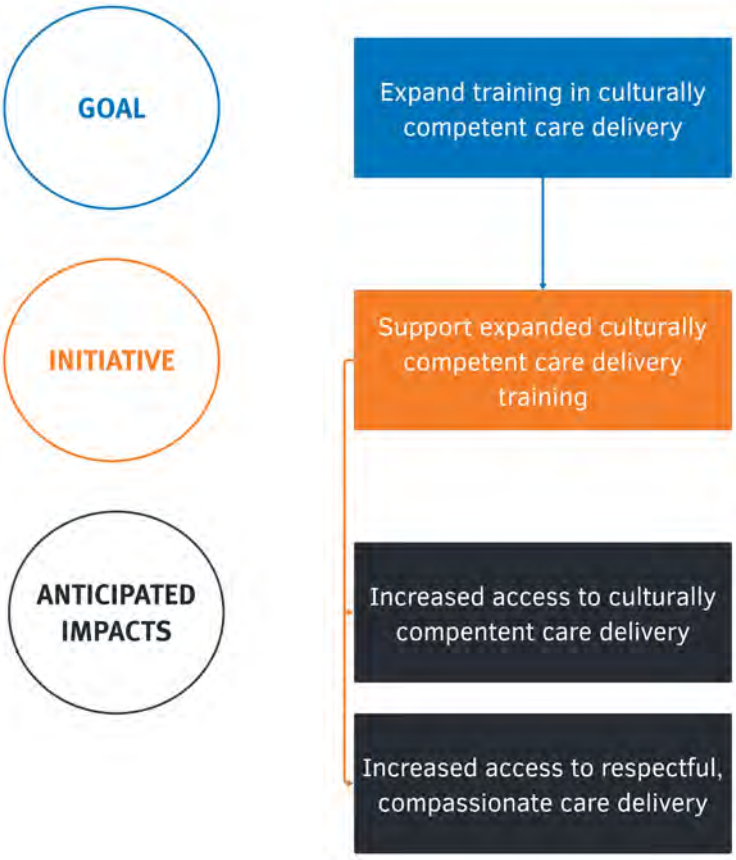
Goal	Initiative	Anticipated Impact
1. Reduce disparities in access to high-quality care	A. Support increased access to primary care and specialty care services for vulnerable individuals[1, 2, 3, 4, 5, 6, 7, 8, 9, 10]	(i) Individuals experience better access to healthcare (ii) Improved healthcare utilization (iii) Reduced unnecessary ED visits and preventable hospitalizations
	B. Support greater access to healthcare in schools[11]	(i) Improved access to healthcare for school-aged children and youth
	C. Support clinical and community health navigator programs[12, 13, 14]	(i) Community members access clinical and community resources that support their plan of care
	D. Support increased use of telehealth and other technology solutions[15, 16, 17]	



Goal	Initiative	Anticipated Impact
2. Increase access to oral healthcare for underserved community members	A. Support school- and community-based programs that offer dental screenings and care, including tele-dentistry[18, 19, 20, 21]	(i) Improved oral health among community members


GOAL
INITIATIVES
ANTICIPATED IMPACTS
Reduce disparities in access to maternal/infant healthcare
Support effective pregnancy prevention and parenting education programs
Increase access to and utilization of adequate perinatal care for parents
Increased utilization of adequate perinatal care
Increased access to pregnancy prevention education
Reduced proportions/disparities in unplanned preganancies
Reduce disparities in proportions of women with healthy pregnancies
Reduce disparities in rates of maternal morbidity
Reduce disparities in rates of low birthweight
Reduce disparities in infant mortality
Reduce disparities in access to support services

Goal	Initiative	Anticipated Impact
3. Reduce disparities and inequitable access to maternal/infant healthcare for community members	A. Support effective pregnancy prevention and parenting education programs[22, 23, 24]	(i) Increased utilization of adequate perinatal care (ii) Increased access to pregnancy prevention education (iii) Reduced proportions/ disparities in unplanned pregnancies
	B. Increase access to and utilization of adequate perinatal care for parents[25, 26, 27, 28, 29, 30]	Reduced disparities in: (i) Proportions of women with healthy pregnancies (ii) Rates of maternal morbidity (iii) Rates of low birthweight (iv) Rates of infant mortality (v) Access to support services



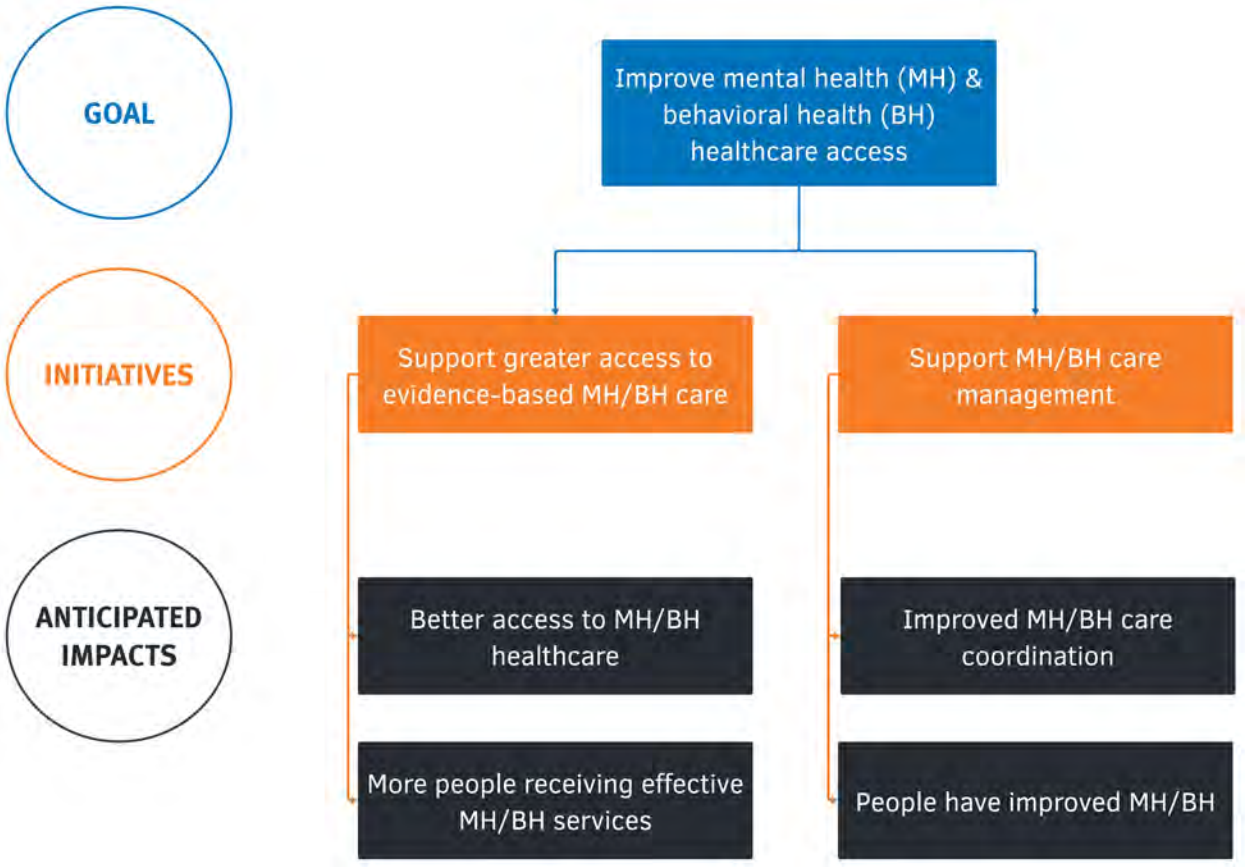
Goal	Initiative	Anticipated Impact
4. Provide/expand workforce training in cultural competence, and compassionate and respectful care delivery	A. Support workforce training in cultural competence, and compassionate and respectful care delivery[31, 32, 33, 34]	(i) Increased access to culturally competent healthcare services among underserved community members, including LGBTQ+ and community members with limited English proficiency (ii) Increased access to compassionate and respectful healthcare among underserved community members, including LGBTQ+ and community members with limited English proficiency

HEALTH CARE ACCESS & DELIVERY (INCLUDING ORAL HEALTH) PROPOSAL RECOMMENDATIONS

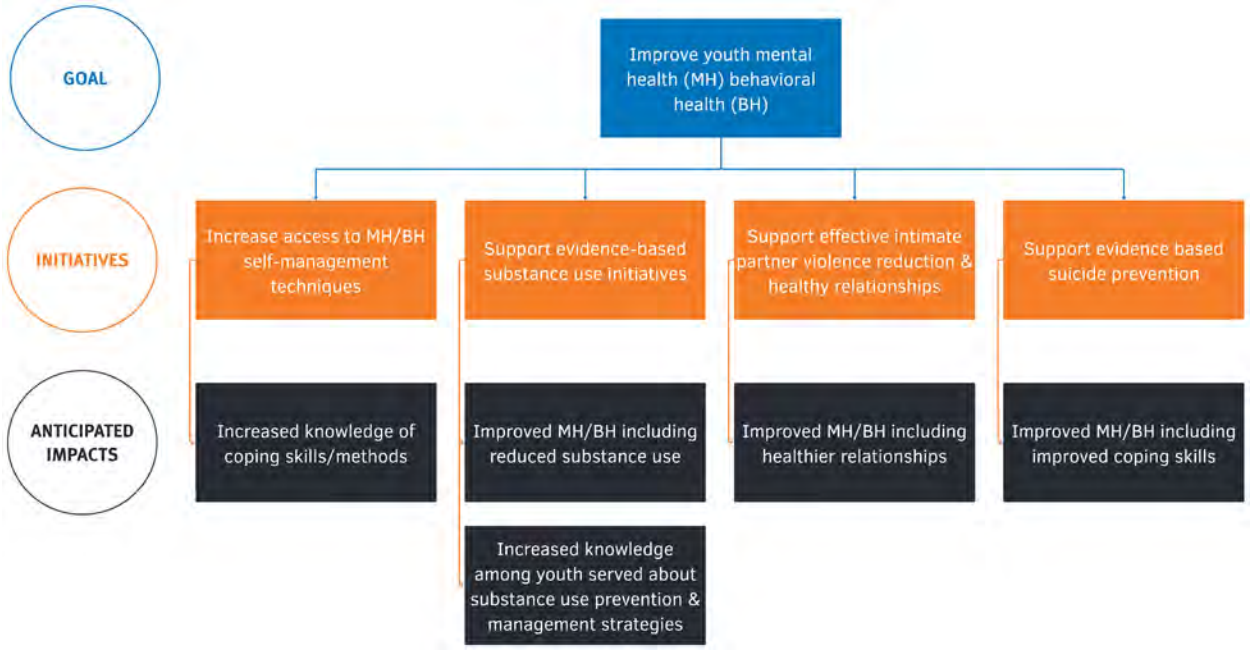
Health Need	Agency	New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC/Staff Recommendation
 Health Care Access & Delivery	Mountain View Whisman School District				X	$ 476,283	$ 305,500	$ 336,000
	On-Site Dental Care Foundation					$ 200,000	$ 200,000	$ 200,000
	Pathways Home Health and Hospice					$ 60,000	$ 60,000	$ 60,000
	Peninsula Healthcare Connection					$ 220,000	$ 220,000	$ 220,000
	Planned Parenthood Mar Monte					$ 250,000	$ 225,000	$ 250,000
	Ravenswood Family Health Network (MayView Clinics)					$ 1,300,000	$ 1,250,000	$ 1,300,000
	Sunnyvale School District				X	$ 664,535	$ 287,000	$ 344,400
	AnewVista Community Services					$ 30,000	$ 20,000	$ 30,000
	Cupertino Union School District			X	X	$ 110,000	$ 105,000	$ 110,000
	El Camino Health - ECHD Population Health Program Manager					$ 247,000	$ 247,000	$ 247,000
	El Camino Health - Health Care Navigation Specialist					$ 150,000	$ 150,000	$ 150,000
	El Camino Health - RoadRunners Transportation Program					$ 165,000	$ 165,000	$ 165,000
	Lucile Packard Foundation for Children's Health					$ 145,000	$ 103,000	$ 103,000
	Santa Clara Valley Healthcare, County of Santa Clara					$ 600,000	$ 326,000	$ 326,000
	El Camino Health - Health Library					$ 175,000	$ 175,000	$ 175,000
	Health Mobile	X		X		$ 150,000	$ -	$ 50,000
	LifeMoves			X		$ 160,000	$ 160,000	$ 160,000
	MedCycle Network	X	X	X		$ 50,000	$ -	$ -
	Vista Center for the Blind and Visually Impaired	X	X	X		$ 46,831	$ -	$ -
					Totals:	$ 5,199,649		$ 4,226,400

BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA)

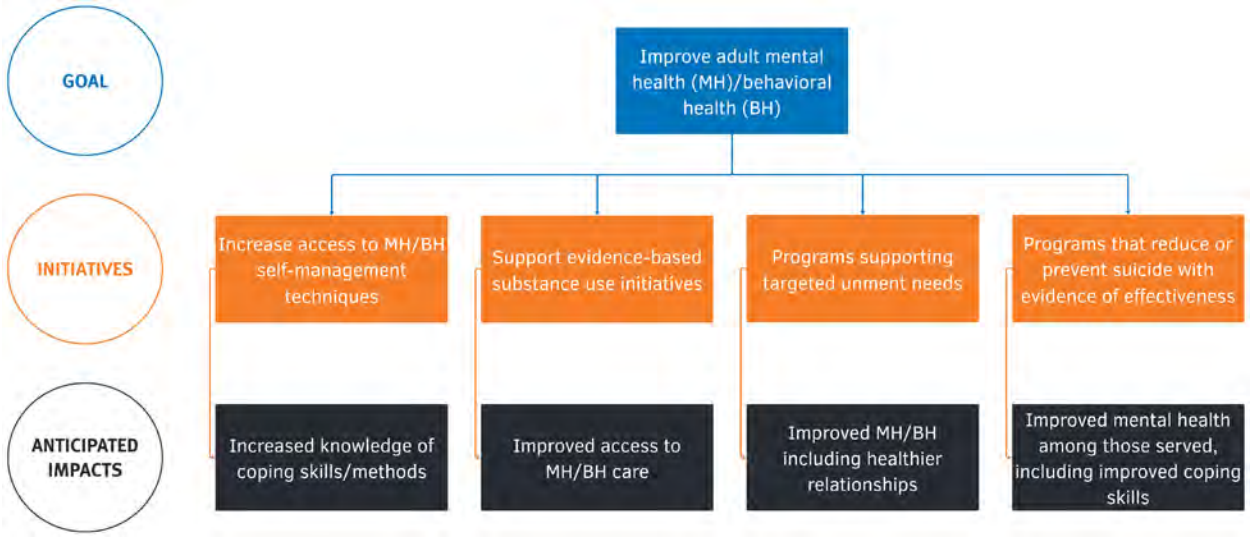
Data indicates that behavioral health (including mental health, trauma, and substance use) continues to be a significant health need, especially with respect to the supply of providers. Community input during the 2025 CHNA emphasized how much worse and more widespread behavioral health issues have become, in part due to the pandemic. Therefore, in addition to supporting initiatives to improve community members' access to mental and behavioral healthcare, El Camino Healthcare District chose goals that support more direct approaches to improving the mental and behavioral health of both youth and adult community members. By using a two-pronged approach, addressing access to care as well as care itself, El Camino Healthcare District expects to be able to make a positive impact by improving community members' mental and behavioral health, including contributing to improved coping skills, healthier relationships, and reduced substance use. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Improve behavioral healthcare access for community members	A. Support in-person and virtual expanded access to evidence-based counseling, addiction treatment, behavioral health case management, etc. [35, 36, 37, 38, 39]	(i) Improved access to mental/behavioral health programs and services (ii) More community members receiving effective mental/ behavioral health services
	B. Care management to support community members' self-management and mental health[40, 41]	(i) Improved coordination of mental/behavioral services (ii) Improved mental/behavioral health among those served



Goal	Initiative	Anticipated Impact
2. Improve behavioral health of youth in the community	A. In-person or virtual programs for assisting youth in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[42, 43]	(i) Increased knowledge among youth served about methods of coping with stress and depression
	B. Support for substance use prevention and intervention initiatives with evidence of effectiveness[44, 45, 46]	(i) Improved mental health among those served, including reduced substance use (ii) Increased knowledge among youth served about substance use prevention and management strategies
	C. Programs that prevent or reduce youth and young adult intimate partner and sexual violence and promote healthier relationships[47, 48]	(i) Improved mental health among those served, including healthier relationships
	D. Programs that reduce or prevent suicide with evidence of effectiveness[49, 50]	(i) Improved mental health among those served, including improved coping skills



Goal	Initiative	Anticipated Impact
3. Improve behavioral health of adults in the community	A. In-person or virtual programs for assisting community members in self-management techniques to reduce depression and anxiety, and for stress, coping, and resilience[51, 52, 53]	(i) Increased knowledge among those served about methods of coping with depression, anxiety, and stress
	B. Support for screening, accurate diagnosis, effective treatment, and follow-up for behavioral health and substance use/addiction treatment services[54, 55, 56]	(i) Improved access to mental and behavioral health services among those served
	C. Programs that support targeted unmet needs such as supporting expectant parents and parents of infants, isolated older adults, individuals experiencing or at risk of homelessness or intimate partner violence[57, 58, 59, 60]	(i) Improved mental health among those served (ii) Improved utilization of clinical and community resources among those served
	D. Programs that reduce or prevent suicide with evidence of effectiveness [61, 62, 63]	(i) Improved mental health among those served, including improved coping skills

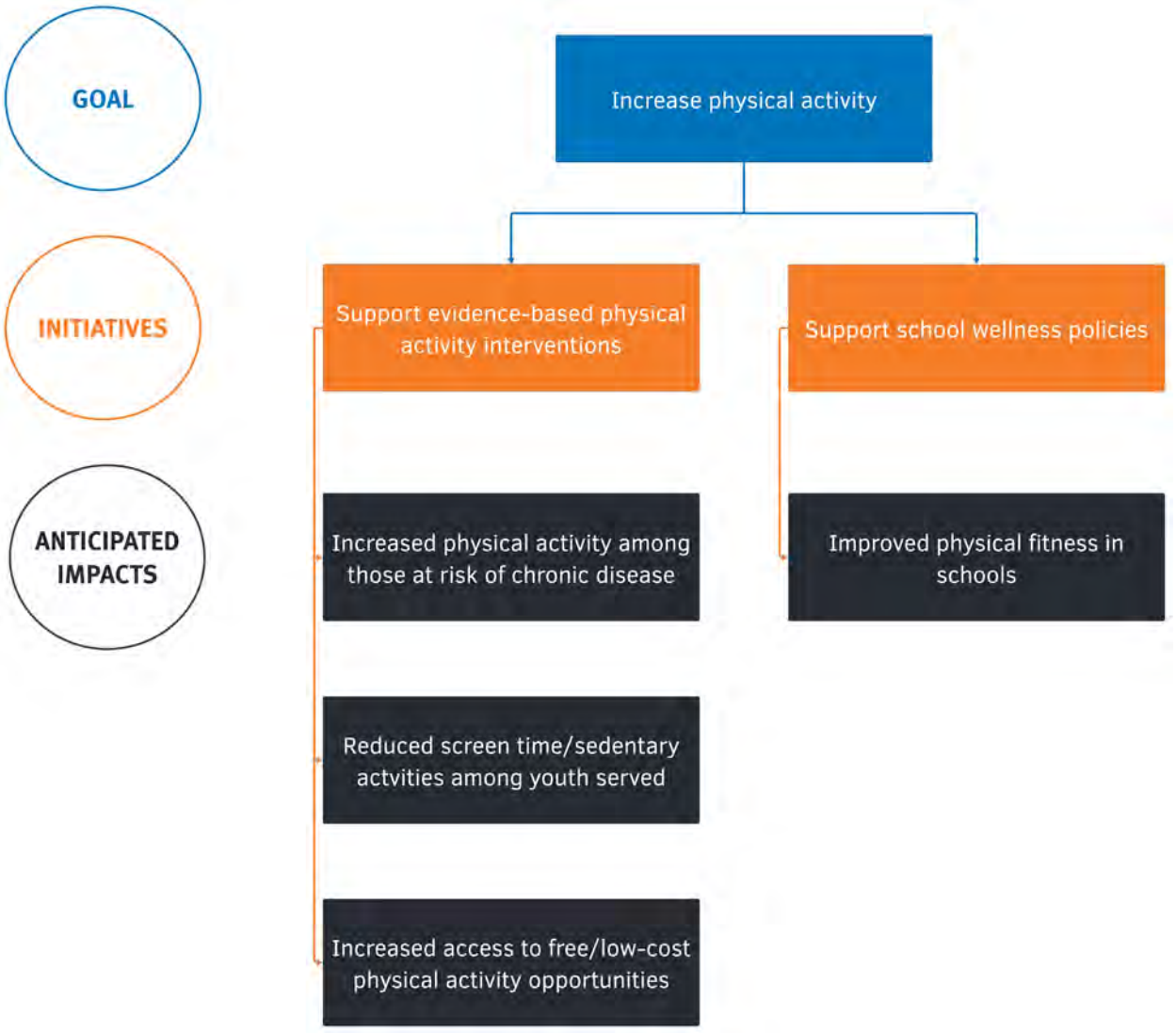
BEHAVIORAL HEALTH (INCLUDING DOMESTIC VIOLENCE AND TRAUMA) PROPOSAL RECOMMENDATIONS

***Note: The Avenidas grant amount will be confirmed in separate vote. Dr. Peter Fung will be recused from the discussion and vote due to conflict of interest.*

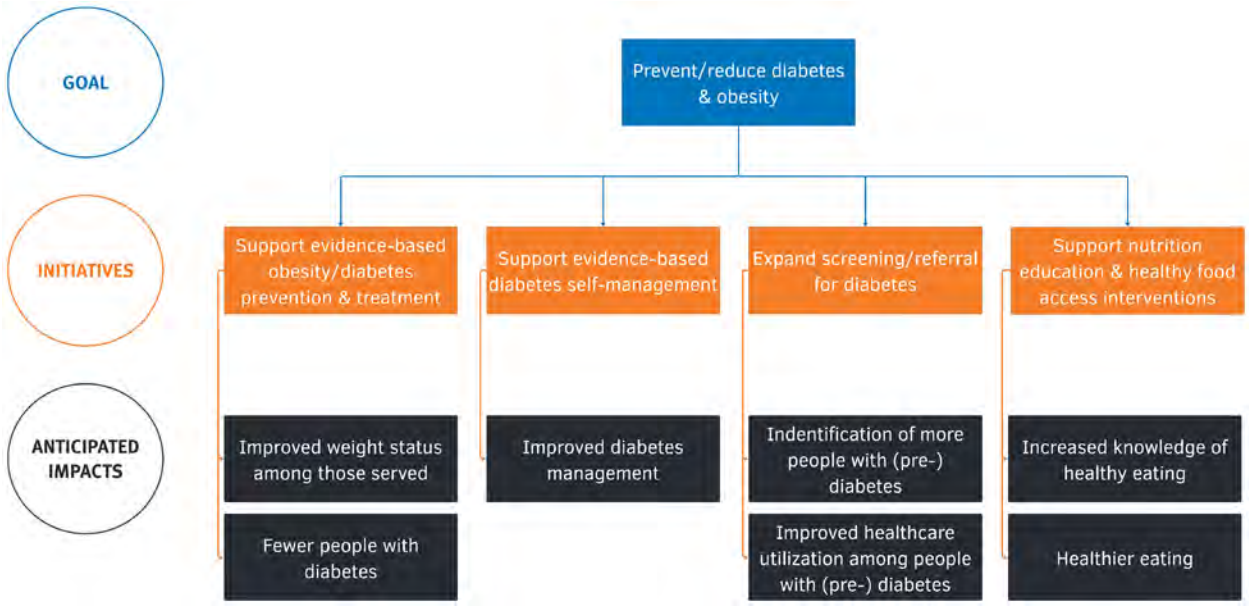
Health Need	Agency	New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC/Staff Recommendation
 Behavioral Health	Avenidas					$ 74,200	$ 70,000	$ 74,200
	Caminar - Domestic Violence Program					$ 131,791	$ 85,000	$ 95,000
	Caminar - LGBTQ Speaker Bureau Program			X		$ 157,945	$ 75,000	$ 78,700
	Eating Disorders Resource Center					$ 25,000	$ 25,000	$ 25,000
	Kara					$ 30,000	$ 30,000	$ 30,000
	Law Foundation of Silicon Valley					$ 70,000	$ 70,000	$ 70,000
	Maitri					$ 50,000	$ 50,000	$ 50,000
	Momentum for Health			X		$ 290,000	$ 290,000	$ 290,000
	National Alliance on Mental Illness - Santa Clara County					$ 120,000	$ 100,000	$ 120,000
	Pacific Clinics				X	$ 340,000	$ 304,000	$ 304,000
	Acknowledge Alliance					$ 80,000	$ 55,000	$ 60,000
	Counseling and Support Services for Youth	X	X		X	$ 29,600	$ -	$ -
	Cupertino Union School District			X	X	$ 112,000	$ 102,500	$ 102,500
	Fremont Union High School District	X	X		X	$ 132,000	$ -	$ -
	Friends For Youth			X		$ 30,000	$ 30,000	$ 30,000
	Health Connected *(formerly My Digital TAT2)*					$ 28,919	$ 29,000	$ 28,900
	Lighthouse of Hope Counseling Center					$ 40,000	$ 30,000	$ 30,000
	Los Altos School District				X	$ 173,000	$ 150,000	$ 150,000
	Mountain View-Los Altos Union High School District				X	$ 231,000	$ 220,000	$ 220,000
	YWCA Golden Gate Silicon Valley					$ 105,000	$ 90,000	$ 105,000
	Friendly Voices - Phone Buddies for Seniors					$ 14,500	$ 11,000	$ 14,500
	Lotus Family Services	X	X			$ 30,000	$ -	$ -
	Positive Alternative Recreation Teambuilding Impact	X	X			$ 30,000	$ -	$ -
	Project Safety Net Inc.	X	X			$ 44,451	$ -	$ -
	Red-White and Blue Charity	X	X			$ 167,700	$ -	$ -
	Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL)	X	X			$ 10,000	$ -	$ -
	Youth Community Service (YCS)	X	X			$ 30,000	$ -	$ -
					Totals:	$ 2,577,106		$ 1,877,800

DIABETES & OBESITY

During the 2025 CHNA, community members provided input on prediabetes and the lack of access to safe spaces for physical activity, both of which are related to diabetes and obesity. Additionally, CHNA data indicated issues with diabetes, as well as both ethnic and geographic disparities in diabetes statistics, and youth physical fitness including ethnic disparities, among other factors. To address these issues, El Camino Healthcare District chose goals that support initiatives that prevent or reduce obesity and diabetes, as well as those that increase physical activity, reduce food insecurity, and increase healthy food access among community members. The hospital expects these efforts will make a positive impact by contributing to improved weight status, improved diabetes management, and reduced rates of obesity & diabetes in the community. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Increase physical activity among community members	A. Support physical activity interventions shown to contribute to weight loss and reduced screen time among youth and adults[64, 65, 66, 67]	(i) Increase in physical activity among youth and adults at elevated risk of chronic health conditions (ii) Reduced screen time & time on sedentary activities among youth served (iii) Increased access to and utilization of free/low-cost opportunities for physical activity
	B. Support implementation of school wellness policies for promoting physical activity[68]	(i) Improved physical fitness among students in schools served



Goal	Initiative	Anticipated Impact
2. Prevent/reduce obesity & diabetes among community members	A. Support obesity/diabetes prevention and obesity treatment programs with evidence of effectiveness[69, 70, 71, 72, 73, 74, 75, 76, 77]	(i) Improved weight status in youth and adults served (ii) Long-term reduction in the number of community members with diabetes
	B. Support diabetes treatment/ self-management programs with evidence of effectiveness[78, 79, 80, 81, 82]	(i) Improved diabetes management in participants served
	C. Expand screening and referral for abnormal blood glucose/pre-diabetes and type 2 diabetes[83, 84]	(i) Identification of more individuals with diabetes and pre-diabetes (ii) Improved healthcare utilization for individuals with diabetes and pre-diabetes

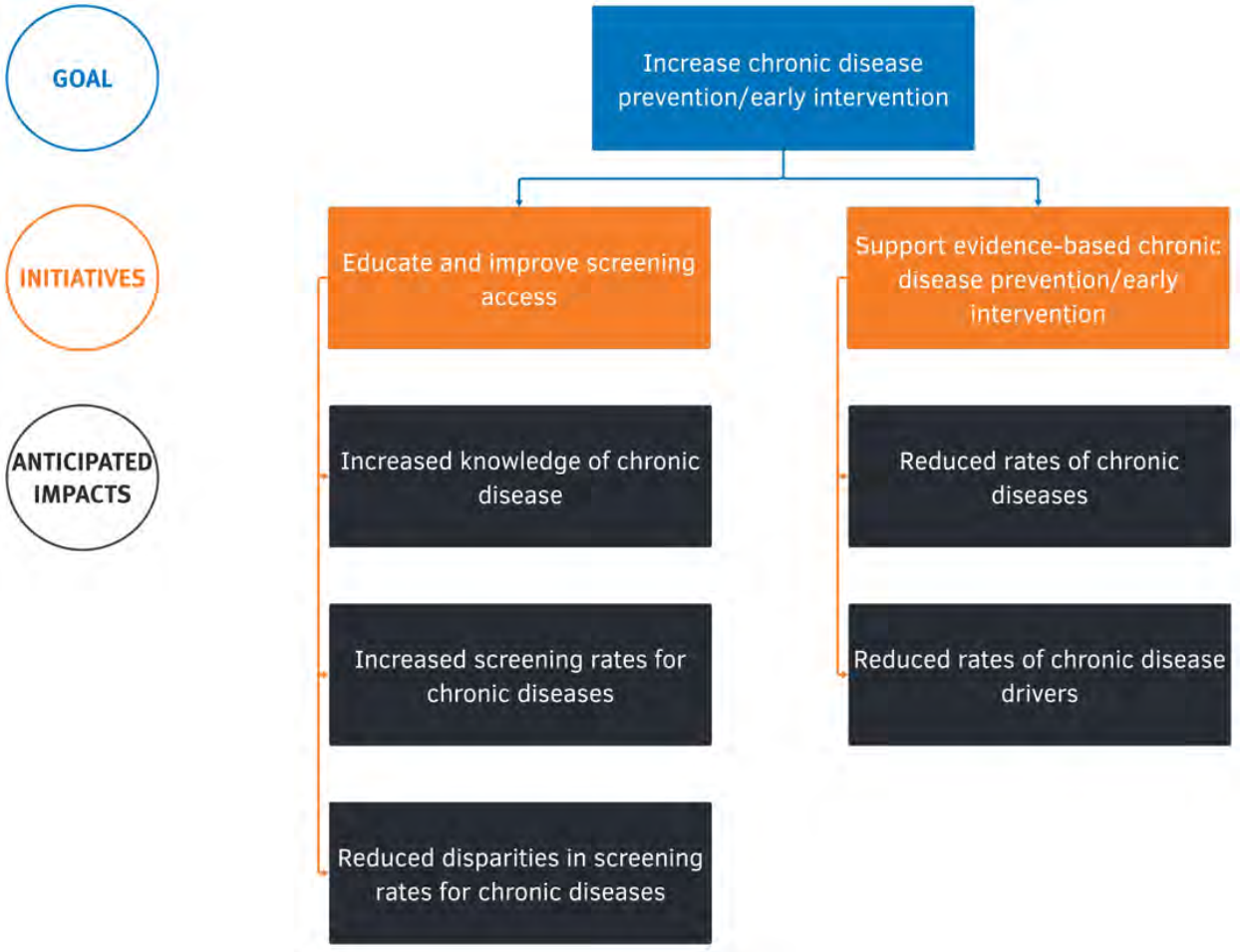
Goal	Initiative	Anticipated Impact
	D. Support community and school-based nutrition education and healthy food access interventions (i.e. school/ community gardening interventions, healthy cooking curricula, food resource management, community health workers, etc.)[85, 86, 87, 88]	(i) Increased knowledge and understanding about healthy eating among people served (ii) Healthier eating among community members receiving interventions

DIABETES & OBESITY PROPOSAL RECOMMENDATIONS

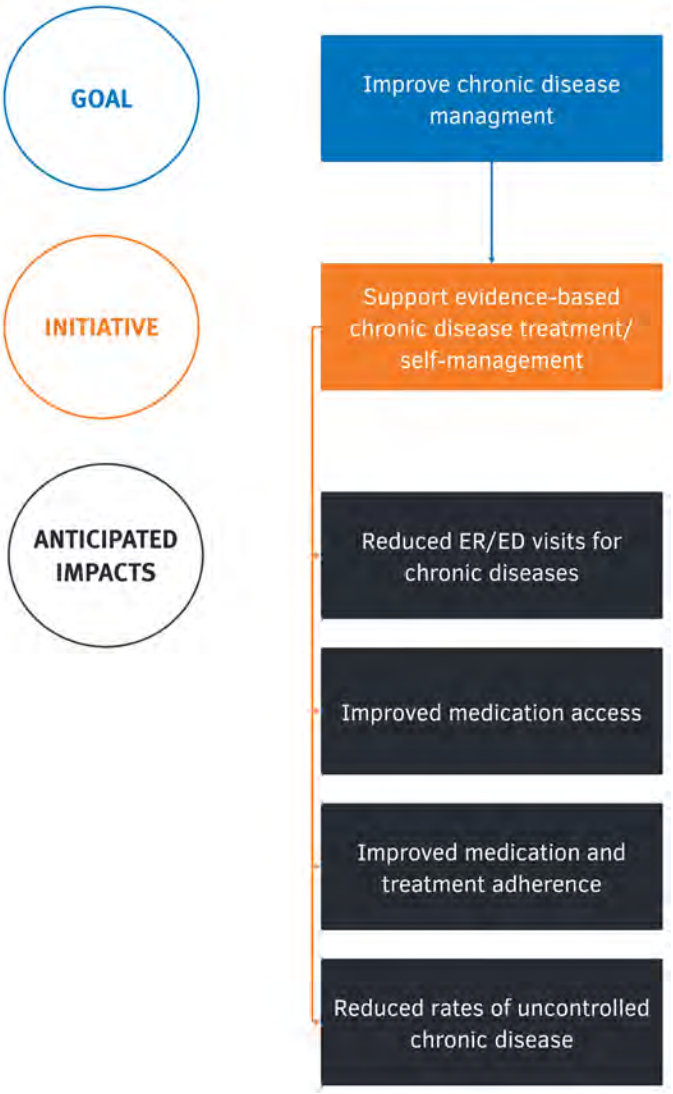
Health Need	Agency	New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC/Staff Recommendation
 Diabetes & Obesity	Chinese Health Initiative (CHI)			X		$ 290,000	$ 275,000	$ 275,000
	City of Sunnyvale - Columbia Neighborhood Center					$ 57,200	$ 49,000	$ 57,200
	Living Classroom					$ 67,000	$ 60,000	$ 67,000
	Playworks, Northern California			X		$ 228,819	$ 200,000	$ 228,800
	YMCA of Silicon Valley					$ 82,620	$ 80,000	$ 82,600
	American Diabetes Association					$ 30,000	$ 30,000	$ 30,000
	Bay Area Women's Sports Initiative - Girls Program			X		$ 84,716	$ 39,000	$ 39,000
	Fresh Approach					$ 75,000	$ 40,000	$ 50,000
	Silicon Valley Bicycle Coalition					$ 30,000	$ 20,000	$ 30,000
	South Asian Heart Center			X		$ 330,000	$ 310,000	$ 310,000
	AbilityPath	X	X			$ 22,124	$ -	$ -
	Bay Area Women's Sports Initiative - Rollers Program					$ 66,000	$ 21,000	$ 21,000
	Roots Community Health	X				$ 89,194	$ -	$ 70,000
					Totals:	$ 1,452,673		$ 1,260,600

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY)

Many chronic diseases are among the top causes of death in Santa Clara County. CHNA data show there are disparities in chronic conditions such as cancer, asthma, heart disease, and stroke. Therefore, El Camino Healthcare District chose goals that support initiatives to increase prevention and early intervention of chronic diseases and to improve chronic disease management among community members. By addressing these issues, El Camino Healthcare District believes it will make a positive impact through improved screening for chronic conditions, reduced rates of uncontrolled chronic diseases, lower levels of the drivers of chronic conditions, and, in the long term, reduced rates of chronic diseases. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Increase prevention and early intervention of chronic diseases in the community	A. Provide education and improve access to screenings[89, 90, 91, 92, 93, 94, 95]	(i) Increased knowledge of chronic disease among community members (ii) Increased rates of screening for chronic disease (iii) Reduced disparities in chronic disease screening rates
	B. Support evidence-based chronic disease prevention and early intervention programs[96, 97, 98]	(i) Reduced rates of chronic diseases (ii) Reduced rates of drivers of chronic diseases, such as physical inactivity, poor nutrition, tobacco and excessive alcohol use, etc.



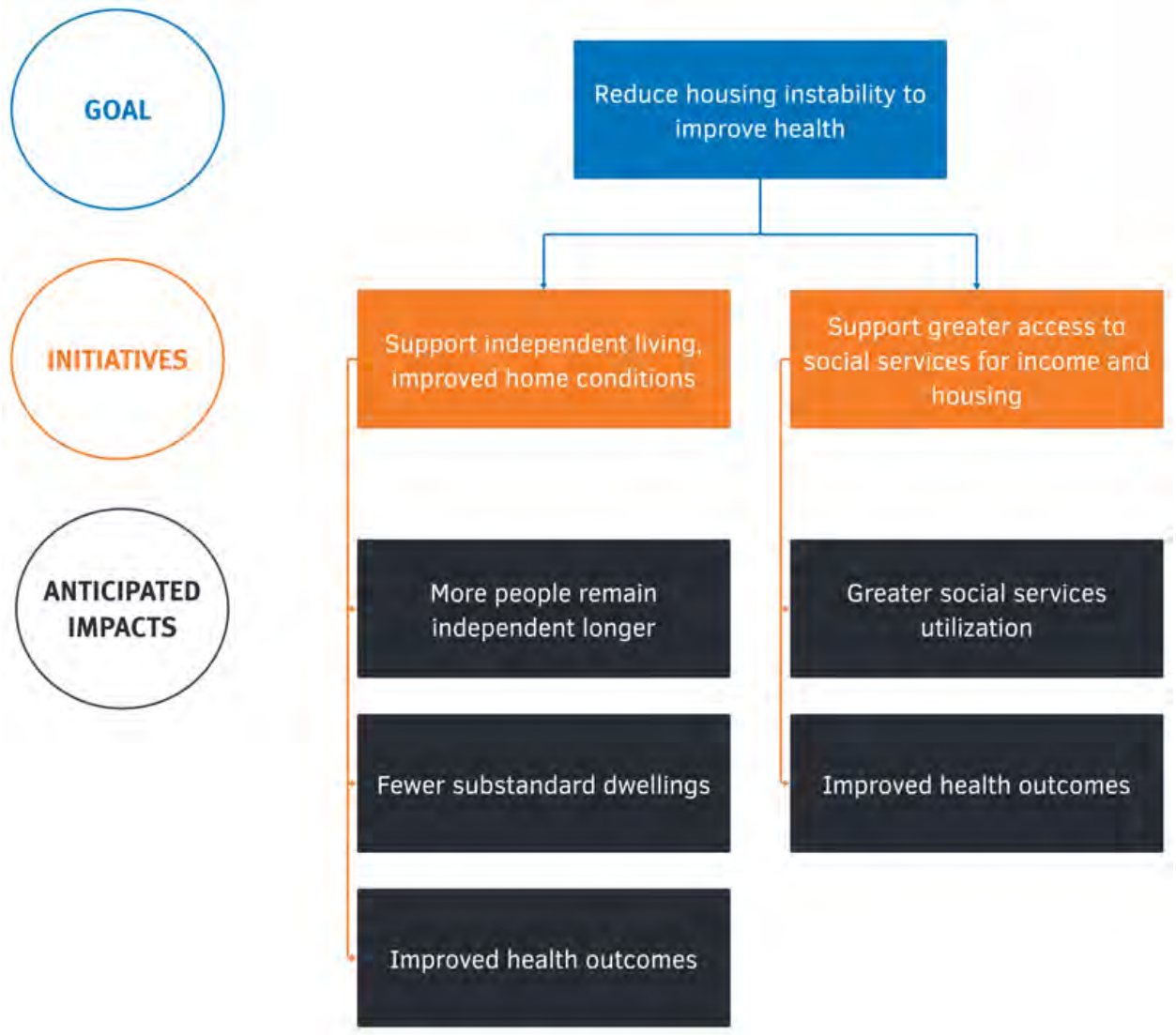
Goal	Initiative	Anticipated Impact
2. Improve chronic disease management among community members	A. Support evidence-based chronic disease treatment and self-management programs[99, 100, 101]	(i) Reduced rates of ER/ED visits for chronic diseases (ii) Improved medication access (iii) Improved medication and treatment adherence (iv) Reduced rates of uncontrolled chronic disease

OTHER CHRONIC CONDITIONS (OTHER THAN DIABETES & OBESITY) PROPOSAL RECOMMENDATIONS

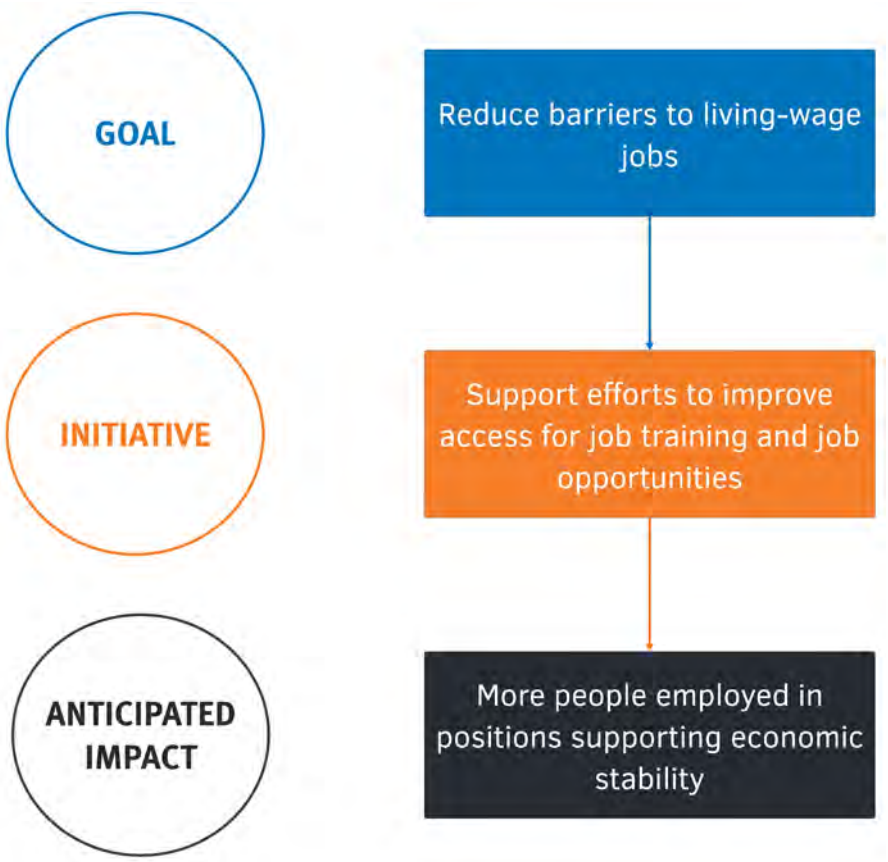
Health Need	Agency	New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC/Staff Recommendation
 Chronic Conditions	Breathe California of the Bay Area, Golden Gate and Central Coast					$ 28,800	$ 28,000	$ 28,800
	Community Services Agency of Mountain View, Los Altos, and Los Altos Hills				X	$ 326,630	$ 240,000	$ 326,600
	American Heart Association					$ 119,249	$ 100,000	$ 119,200
	Stanford Health Care - Trauma Injury Prevention Program Administration	X	X			$ 27,667	$ -	$ -
					Totals:	$ 502,346		$ 474,600

ECONOMIC STABILITY (INCLUDING FOOD SECURITY, HOUSING, AND HOMELESSNESS)

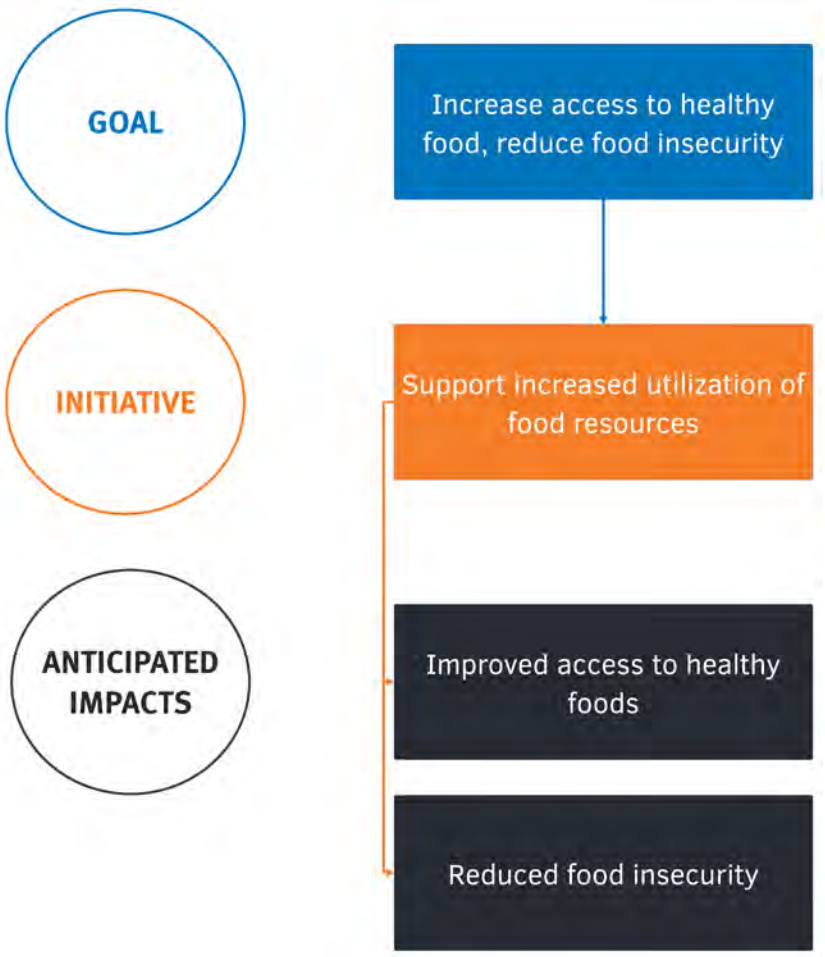
Economic stability was a top priority for the community in the 2025 CHNA, supported by data showing inequities in income, education, housing affordability, and job opportunities. When food, housing, and healthcare are difficult to afford, health outcomes are likely to suffer. Therefore, El Camino Healthcare District chose goals that support initiatives to reduce housing instability, food insecurity, and barriers to living-wage employment. Through efforts to address community members' basic needs, El Camino Healthcare District believes it will make a positive impact via increased utilization of social services and improved well-being and health outcomes among community members. Below and on the following pages, see diagrams for summaries and tables for details.



Goal	Initiative	Anticipated Impact
1. Reduce housing instability among community members	A. Support independent living and efforts to improve substandard living conditions[102, 103, 104]	(i) More community members remain independent longer (ii) Reduced number of sub-standard dwellings (iii) Improved health outcomes for those at-risk of and/or experiencing homelessness
	B. Support efforts to improve access to social services that address income and housing insecurity[105, 106, 107]	(i) Increase in social services utilization (ii) Improved health outcomes for those at-risk of and/or experiencing homelessness



Goal	Initiative	Anticipated Impact
2. Reduce barriers to employment/ careers that provide community members with a living wage	A. Support efforts to improve access to workforce training and employment opportunities for underrepresented populations[108, 109, 110, 111]	(i) More community members employed in positions that support economic stability



Goal	Initiative	Anticipated Impact
3. Reduce food insecurity and increase healthy food access for low-income community members	A. Support increased utilization of healthy/ culturally appropriate food through CalFresh/SNAP enrollment, existing food banks, and other sites[112, 113]	(i) Improved access to healthy food options (ii) Reduced food insecurity

ECONOMIC STABILITY (INCLUDING FOOD INSECURITY, HOUSING, AND HOMELESSNESS) PROPOSAL RECOMMENDATIONS

Health Need	Agency	New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC/Staff Recommendation
 Economic Stability	Day Worker Center of Mountain View					$ 35,000	$ 35,000	$ 35,000
	Hope's Corner Inc					$ 30,000	$ 30,000	$ 30,000
	Mountain View Police Department					$ 30,000	$ 30,000	$ 30,000
	Sunnyvale Community Services - Social Work/Homebound Case Management				X	$ 266,938	$ 207,000	$ 266,900
	Sunnyvale Community Services - Comprehensive Safety Net Services				X	$ 131,750	$ 75,000	$ 131,700
	Rebuilding Together Silicon Valley	X		X		$ 30,000	$ -	$ 30,000
	Second Harvest of Silicon Valley		X			$ 40,000	$ 40,000	$ -
	The United Effort Organization, Inc.					$ 75,000	$ 25,000	$ 30,000
	Downtown Streets Team, Inc.	X	X	X		$ 25,300	$ -	$ -
	Helping Hands Silicon Valley	X				$ 30,000	$ -	$ 20,000
	Rebuilding Together Peninsula	X	X			$ 30,000	$ -	$ -
					Totals:	$ 723,988		$ 573,600

VIII. EVALUATION PLANS

As part of El Camino Healthcare District's ongoing community health improvement efforts, we partner with local safety net providers and community-based nonprofit organizations to fund programs and projects that address health needs identified through our triennial CHNA. Community partnership grant funding supports organizations and programs with a demonstrated ability to improve the health status of the selected health needs through data-driven solutions and results. Grantees are asked to explain the data and/or information that justifies the need for and effectiveness of the proposed program strategies.

El Camino Healthcare District will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. Plans to monitor activities will be tailored to each strategy and will include the collection and documentation of tracking measures, such as the number of grants made, number of dollars spent, and number of people reached/served. In addition, El Camino Healthcare District will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate. Grantees report mid-year and year-end performance on annual outcomes metrics, which are shared broadly with the public as well as state and federal regulatory bodies.

ENDNOTES

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Community Benefit Plan Appendix: FY2026 Proposal Summaries

Plan Appendix includes:

- FY2026 Proposal Index: reflects an overview of each proposal including requested/recommended amounts, current funding, if applicable, and page numbers for corresponding Summaries.

- Proposal Summaries for submitted applications containing:
  - Program title
  - Program Abstract & Target Population
  - Agency description & address
  - Program delivery site(s)
  - Services funded by grant
  - Budget Summary
  - FY2026 funding requested and Community Benefit Advisory Council (CBAC) recommendation
  - Funding history and metric performance, if applicable
  - Dual funding information, if applicable
  - FY2026 proposed metrics

FY2026 ECHD Grant Application Index

Total Requested: $10,455,762 | Total Funded: $8,413,000 | Total Unfunded: $2,042,762

Health Need	Agency		New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC Recommendation
Health Care Access & Delivery Goal % ~50% Recommended % ~50%	Mountain View Whisman School District	6				X	$ 476,283	$ 305,500	$ 336,000
	On-Site Dental Care Foundation	38					$ 200,000	$ 200,000	$ 200,000
	Pathways Home Health and Hospice	39					$ 60,000	$ 60,000	$ 60,000
	Peninsula Healthcare Connection	40					$ 220,000	$ 220,000	$ 220,000
	Planned Parenthood Mar Monte	41					$ 250,000	$ 225,000	$ 250,000
	Ravenswood Family Health Network (MayView Clinics)	43					$ 1,300,000	$ 1,250,000	$ 1,300,000
	Sunnyvale School District	8				X	$ 664,535	$ 287,000	$ 344,400
	AnewVista Community Services	25					$ 30,000	$ 20,000	$ 30,000
	Cupertino Union School District	4			X	X	$ 110,000	$ 105,000	$ 110,000
	El Camino Health - ECHD Population Health Program Manager	29					$ 247,000	$ 247,000	$ 247,000
	El Camino Health - Health Care Navigation Specialist	30					$ 150,000	$ 150,000	$ 150,000
	El Camino Health - RoadRunners Transportation Program	28					$ 165,000	$ 165,000	$ 165,000
	Lucile Packard Foundation for Children's Health	35					$ 145,000	$ 103,000	$ 103,000
	Santa Clara Valley Healthcare, County of Santa Clara	45					$ 600,000	$ 326,000	$ 326,000
	El Camino Health - Health Library	27					$ 175,000	$ 175,000	$ 175,000
	Health Mobile	32	X		X		$ 150,000	$ -	$ 50,000
	LifeMoves	33			X		$ 160,000	$ 160,000	$ 160,000
	MedCycle Network	37	X	X	X		$ 50,000	$ -	$ -
	Vista Center for the Blind and Visually Impaired	46	X	X	X		$ 46,831	$ -	$ -
						Totals:	$ 5,199,649		$ 4,226,400
Behavioral Health Goal % ~25% Recommended % ~22%	Avenidas	50					$ 74,200	$ 70,000	$ 74,200
	Caminar - Domestic Violence Program	52					$ 131,791	$ 85,000	$ 95,000
	Caminar - LGBTQ Speaker Bureau Program	54			X		$ 157,945	$ 75,000	$ 78,700
	Eating Disorders Resource Center	56					$ 25,000	$ 25,000	$ 25,000
	Kara	60					$ 30,000	$ 30,000	$ 30,000
	Law Foundation of Silicon Valley	62					$ 70,000	$ 70,000	$ 70,000
	Maitri	65					$ 50,000	$ 50,000	$ 50,000
	Momentum for Health	66			X		$ 290,000	$ 290,000	$ 290,000
	National Alliance on Mental Illness - Santa Clara County	67					$ 120,000	$ 100,000	$ 120,000
	Pacific Clinics	18				X	$ 340,000	$ 304,000	$ 304,000
	Acknowledge Alliance	48					$ 80,000	$ 55,000	$ 60,000
	Counseling and Support Services for Youth	10	X	X			$ 29,600	$ -	$ -
	Cupertino Union School District	12			X	X	$ 112,000	$ 102,500	$ 102,500
	Fremont Union High School District	14	X	X			$ 132,000	$ -	$ -
	Friends For Youth	58			X		$ 30,000	$ 30,000	$ 30,000
	Health Connected *(formerly My Digital TAT2)*	59					$ 28,919	$ 29,000	$ 28,900
	Lighthouse of Hope Counseling Center	63					$ 40,000	$ 30,000	$ 30,000
	Los Altos School District	15				X	$ 173,000	$ 150,000	$ 150,000
	Mountain View-Los Altos Union High School District	16				X	$ 231,000	$ 220,000	$ 220,000
	YWCA Golden Gate Silicon Valley	76					$ 105,000	$ 90,000	$ 105,000

DNF: Do Not Fund recommendation
New: New program to Community Benefit in FY2026
Dual Request: Program requested dual funding from ECH + ECHD

Green represents higher proposal strength
Blue represents medium proposal strength
Grey represents lower proposal strength

Two-year grant summary sheets are presented first by health need. Subsequent proposal summary sheets are organized alphabetically within each health need and do not necessarily correspond with the index order.

FY2026 ECHD Grant Application Index

Total Requested: $10,455,762 | Total Funded: $8,413,000 | Total Unfunded: $2,042,762

Health Need	Agency		New	DNF	Dual	Two-Year Grant	Requested	FY2025 Approved (if applicable)	CBAC Recommendation
Behavioral Health	Friendly Voices - Phone Buddies for Seniors	57					$ 14,500	$ 11,000	$ 14,500
	Lotus Family Services	64	X	X			$ 30,000	$ -	$ -
	Positive Alternative Recreation Teambuilding Impact	69	X	X			$ 30,000	$ -	$ -
	Project Safety Net Inc.	71	X	X			$ 44,451	$ -	$ -
	Red-White and Blue Charity	72	X	X			$ 167,700	$ -	$ -
	Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL)	74	X	X			$ 10,000	$ -	$ -
	Youth Community Service (YCS)	75	X	X			$ 30,000	$ -	$ -
						Totals:	**$ 2,577,106**		**$ 1,877,800**
Diabetes & Obesity Goal % ~15% Recommended % ~15%	Chinese Health Initiative (CHI)	83			X		$ 290,000	$ 275,000	$ 275,000
	City of Sunnyvale - Columbia Neighborhood Center	85					$ 57,200	$ 49,000	$ 57,200
	Living Classroom	88					$ 67,000	$ 60,000	$ 67,000
	Playworks, Northern California	90			X		$ 228,819	$ 200,000	$ 228,800
	YMCA of Silicon Valley	97					$ 82,620	$ 80,000	$ 82,600
	American Diabetes Association	79					$ 30,000	$ 30,000	$ 30,000
	Bay Area Women's Sports Initiative - Girls Program	80			X		$ 84,716	$ 39,000	$ 39,000
	Fresh Approach	86					$ 75,000	$ 40,000	$ 50,000
	Silicon Valley Bicycle Coalition	94					$ 30,000	$ 20,000	$ 30,000
	South Asian Heart Center	95			X		$ 330,000	$ 310,000	$ 310,000
	AbilityPath	78	X	X			$ 22,124	$ -	$ -
	Bay Area Women's Sports Initiative - Rollers Program	82					$ 66,000	$ 21,000	$ 21,000
	Roots Community Health	92	X				$ 89,194	$ -	$ 70,000
						Totals:	**$ 1,452,673**		**$ 1,260,600**
Chronic Conditions Goal % ~5% Recommended % ~6%	Breathe California of the Bay Area, Golden Gate and Central Coast	101					$ 28,800	$ 28,000	$ 28,800
	Community Services Agency of Mountain View, Los Altos, and Los Altos Hills	20				X	$ 326,630	$ 240,000	$ 326,600
	American Heart Association	99					$ 119,249	$ 100,000	$ 119,200
	Stanford Health Care - Trauma Injury Prevention Program Administration	103	X	X			$ 27,667	$ -	$ -
						Totals:	**$ 502,346**		**$ 474,600**
Economic Stability Goal % ~5% Recommended % ~7%	Day Worker Center of Mountain View	105					$ 35,000	$ 35,000	$ 35,000
	Hope's Corner Inc	110					$ 30,000	$ 30,000	$ 30,000
	Mountain View Police Department	111					$ 30,000	$ 30,000	$ 30,000
	Sunnyvale Community Services - Social Work/Homebound Case Management	22				X	$ 266,938	$ 207,000	$ 266,900
	Sunnyvale Community Services - Comprehensive Safety Net Services	24				X	$ 131,750	$ 75,000	$ 131,700
	Rebuilding Together Silicon Valley	114	X		X		$ 30,000	$ -	$ 30,000
	Second Harvest of Silicon Valley	116		X			$ 40,000	$ 40,000	$ -
	The United Effort Organization, Inc.	118					$ 75,000	$ 25,000	$ 30,000
	Downtown Streets Team, Inc.	106	X	X	X		$ 25,300	$ -	$ -
	Helping Hands Silicon Valley	108	X				$ 30,000	$ -	$ 20,000
	Rebuilding Together Peninsula	112	X	X			$ 30,000	$ -	$ -
						Totals:	**$ 723,988**		**$ 573,600**

DNF: Do Not Fund recommendation
New: New program to Community Benefit in FY2026
Dual Request: Program requested dual funding from ECH + ECHD

Green represents higher proposal strength
Blue represents medium proposal strength
Grey represents lower proposal strength

Two-year grant summary sheets are presented first by health need. Subsequent proposal summary sheets are organized alphabetically within each health need and do not necessarily correspond with the index order.

FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Cupertino Union School District – Two Year Application

Program Title	Student Health Services	***Recommended Amount:*** $110,000
Program Abstract & Target Population	Licensed vocational nurse provides healthcare services including vaccines, screenings, assessments, development of health and safety plans, and administration of medication and specialized procedures for transitional kindergarten through 8th grade students at two Cupertino Union School District sites within ECHD.	
Agency Description & Address	10301 Vista Drive Cupertino, CA 95014 https://www.cusdk8.org/ Located in the heart of Silicon Valley, Cupertino Union School District (CUSD) is a Local Education Agency providing public education and consistently ranking amongst the top performing elementary (TK-8th) school districts in California. The largest elementary school district in northern California, CUSD is comprised of nearly 1,400 employees serving approximately 13,500 students in 17 elementary schools, one K-8 school, and five middle schools located through Cupertino and parts of Sunnyvale, San Jose, Saratoga, Los Altos, and Santa Clara. The mission of CUSD focuses on relevant and rigorous instruction, personalized learning, and a whole-child approach to preparing our students for success. District families and staff join as partners to develop creative, exemplary learners with the skills and enthusiasm to contribute to a constantly changing global society.	
Program Delivery Site(s)	• Chester Nimitz Elementary, 45 Cheyenne Drive, Sunnyvale, CA 94087 • West Valley Elementary,1635 Belleville Way, Sunnyvale, CA 94087	
Services Funded By Grant	• Day-to-day nursing assessment, care, and documentation of illness & injury • Ongoing recording and monitoring of students with special medical needs • Collaboration with primary and specialized care providers for specialized needs • Administration of medications and procedures for students requiring them at school • Annual and as-needed vision hearing screenings and oral health assessments • Annual and ongoing evaluation of immunization status for all students • Health history and physical assessment of students considered for IEP, development of 504 Plans, development and implementation of Individualized Student Health Plans • Development and implementation of health and safety protocols • Training of unlicensed personnel to perform scope-appropriate medical care • Development/implementation of student health and nutrition education programs	
Budget Summary	Full requested amount funds a portion of a licensed vocational nurse salary, contract CPR instructors, contracted services for school-based vaccine clinics and some health offices supplies.	
FY2026-FY2027 Funding	FY2026 Requested: $110,000 ($220,000 over two years)	FY2026 Recommended: $110,000 ($220,000 over two years)

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $105,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $105,000 FY2024 Spent: $105,000 FY2024 Annual metrics met: 95%	FY2023 Approved: $100,000 FY2023 Spent: $100,000 FY2023 Annual metrics met: 89%

FY2026 Dual Funding	FY2026 Requested: $110,000	FY2026 Recommended: $110,000

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FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

Cupertino Union School District

[Continued from previous page]

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $110,000 FY2025 6-month metrics met:100%	FY2024 Approved: $110,000 FY2024 Spent: $110,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $100,000 FY2023 Spent: $100,000 FY2023 Annual metrics met: 81%

	Metrics	***6-month Target***	***Annual Target***
FY2026 Proposed Metrics	Individuals served	540	780
	Services provided	1,300	2,100
	Number of individuals receiving follow-up care after a health screening	25	65
	Increase vaccine compliance to prevent exclusion from school - percentage of student who are noncompliant with vaccines who become compliant as a result of school health services intervention.	95%	100%

FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Mountain View Whisman School District – Two Year Application

Program Title	Health Services Grant	***Recommended Amount:*** $336,000	
Program Abstract & Target Population	Licensed vocational nurses and a registered nurse provide health services including, support for vaccines, screenings, assessments, emergency response and on-call support, and administration of medication and specialized procedures to transitional kindergarten through 8th grade students at all sites in the Mountain View Whisman School District.		
Agency Description & Address	1400 Montecito Avenue Mountain View, CA 94043 http://mvwsd.org Mountain View Whisman School District (MVWSD) is located in Mountain View, CA, in the heart of Silicon Valley. MVWSD serves a diverse student population from preschool through eighth grade representing a wide range of ethnicities, languages, cultures, and economic status. Mountain View Whisman School District's mission is to demonstrate a relentless commitment to the success of every child on a daily basis. Our priorities are academic excellence, strong community, and a broad worldview. We prepare our students for the world ahead by challenging, inspiring, and supporting them to thrive in a world of constant change.		
Program Delivery Site(s)	• Benjamin Bubb Elementary, 525 Hans Ave, Mountain View, CA 94040 • Mariano Castro Elementary, 500 Toft St, Mountain View, CA 94041 • Amy Imai Elementary, 253 Martens Ave, Mountain View, CA 94040 • Landels Elementary, 115 W Dana St, Mountain View, CA 94041 • Gabriela Mistral Elementary, 505 Escuela Ave, Mountain View, CA 94040 • Monta Loma Elementary, 460 Thompson Ave, Mountain View, CA 94043 • Stevenson Elementary, 750 San Pierre Way Ste B, Mountain View, CA 94043 • Theuerkauf Elementary, 1625 San Luis Ave, Mountain View, CA 94043 • Jose Antonio Vargas Elementary, 220 N Whisman Rd, Mountain View, CA 94043 • Crittenden Middle School, 1701 Rock St, Mountain View, CA 94043 • Graham Middle School, 1175 Castro St, Mountain View, CA 94040		
Services Funded By Grant	• Vision and hearing screenings during state mandated grade levels (transitional/kindergarten, 2nd, 5th, and 8th grade), as well as for initial and triennial assessments for IEPs. • Oral Health Exam: one time requirement in kindergarten • Child Health and Disability Prevention Exam: one time requirement in 1st grade • One on one health care for students with chronic health conditions such as diabetes, G-tube feedings, trach care, chronic cardiac conditions, daily medication administration, etc. • Emergency responses to injured and ill students. Provide telehealth support as needed and on call for health concerns. • Staff Training/education (i.e. CPR, First Aid, Medication Administration) • Health assessments for students requiring specialized education plans. • Ongoing immunization compliance review and outreach support. • Screening students in preparation for 5th grade science camp (head lice, temperature, and reviewing medications).		
Budget Summary	Full requested amount funds partial salary and benefits for licensed vocational nurses and registered nurse.		
FY2026-FY2027 Funding	FY2026 Requested:	$476,283 ($952,566 over two years)	FY2026 Recommended:	$336,000 ($672,000 over two years)

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FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

Mountain View Whisman School District

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Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $305,500 FY2025 6-month metrics met: 100%	FY2024 Approved: $305,500 FY2024 Spent: $305,500 FY2024 Annual metrics met:84%	FY2023 Approved: $290,000 FY2023 Spent: $290,000 FY2023 Annual metrics met: 83%
FY2026-FY2027 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	1,962	3,925
	Services provided	8,000	10,500
	Number of individuals receiving follow-up care after a health screening	25	100
	Students out of compliance with required immunizations who become compliant.	95%	98%

FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Sunnyvale School District – Two Year Application

Program Title	Healthcare Grant	***Recommended Amount:*** $344,400	
Program Abstract & Target Population	Nurses and health assistants provide health screenings, assessments, and services for elementary school students at all 10 sites of Sunnyvale Elementary School District.		
Agency Description & Address	819 West Iowa Avenue Sunnyvale, CA 94086 http://www.sesd.org Sunnyvale School District's Promise is that "Every student is known by name, strength and need, ready to excel in high school and beyond, and to lead a life of joy and purpose." Per the Equity Statement, "In Sunnyvale School District we believe that equity and anti-racist practices lead to learning without limits". The team includes 992 highly qualified educators, administrators, and support staff whose primary goal is to enable the approximately 5900 students enrolled in our schools to achieve academic success. The district is comprised of a comprehensive preschool program, eight elementary schools serving students in transitional kindergarten through fifth grade, and two middle schools serving students in sixth through eighth grade.		
Program Delivery Site(s)	• Bishop Elementary School, 450 N. Sunnyvale Ave., Sunnyvale, CA 94085 • Cherry Chase Elementary School, 1138 Heatherstone Way, Sunnyvale, CA 94087 • Columbia Middle School, 739 Morse Ave., Sunnyvale, CA 94085 • Cumberland Elementary School, 824 Cumberland Drive, Sunnyvale, CA 94087 • Ellis Elementary School 550 E. Olive Ave., Sunnyvale, CA 94086 • Fairwood Explorer Elementary School, 1110 Fairwood Ave., Sunnyvale, CA 94089 • Lakewood Elementary School, 750 Lakechime Dr., Sunnyvale, CA 94089 • San Miguel Elementary School, 777 San Miguel Ave., Sunnyvale, CA 94085 • Sunnyvale Middle School, 1080 Mango Ave., Sunnyvale, CA 94087 • Vargas Elementary School, 1054 Carson Dr., Sunnyvale, CA 94086		
Services Funded By Grant	• Collaborate with healthcare providers/parents to create and implement individualized healthcare plans for students with chronic medical conditions. • Inform school staff of students' medical conditions and provide appropriate training based on individualized needs of students. • Provide vision and hearing screening for students in grade levels: TK, K, 2, 5 and 8 as well as students in special education and provide follow up for students who failed the screenings. • Follow up on students who do not have an Oral Health Assessment on file • Refer uninsured or underinsured students to the Lions Club or Ainak to receive free eye exams and free eyeglasses. • Provide case management for students with attendance issues where the barrier for attending school is health related. • Participate in IEP meetings, MTSS meetings, 504 plan meetings and SARB meetings as needed to provide medical expertise to the team.		
Budget Summary	Full requested amount funds 2 FTE nurses and 1.8 FTE health assistants' salary and benefits and some program support costs.		
FY2026-FY2027 Funding	FY2026 Requested:	$664,535 ($1,329,070 over two years)	FY2026 Recommended:	$344,400 ($688,800 over two years)

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FY2026-FY2027 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

Sunnyvale School District

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Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $287,000 FY2025 6-month metrics met: 98%	FY2024 Approved: $287,000 FY2024 Spent: $287,000 FY2024 Annual metrics met: 99%	FY2023 Approved: $287,000 FY2023 Spent: $287,000 FY2023 Annual metrics met: 98%

	Metrics	***6-month Target***	***Annual Target***
FY2026-FY2027 Proposed Metrics	Individuals served	2,063	4,125
	Services provided	4,027	8,054
	Number of individuals receiving follow-up care after a health screening	85	184
	Students who failed vision or hearing screening and saw their healthcare provider	26%	56%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Counseling and Support Services for Youth

Program Title	Mountain View Los Altos School-Based Mental Health Counseling	***Recommended Amount:*** DNF
Program Abstract & Target Population	MFT and MSW therapists provide school-based mental health services students through individual/group therapy, check-ins, and psychosocial education, along with family/staff consultations and support for schools in the Mountain View Los Altos School District and Mountain View students at two private schools: Khan Lab Schools.	
Agency Description & Address	544 Valley Way Milpitas, CA 95035 http://www.cassybayarea.org Counseling and Support Services for Youth (CASSY) destigmatizes mental health services and makes supporting students' social and emotional well-being the norm in our local schools. CASSY partners with districts to provide professional, on-campus mental health services to students and their families free of charge – providing a mental health safety net for 20,395 youth across 35 public and private Bay Area schools. After participating in MVLA's rigorous RFP process to find a new mental health partner, CASSY was selected to exclusively offer comprehensive mental health support at the three MVLA High School District schools for the 2024-2025 school year. Additionally, CASSY brings longstanding commitment to youth mental wellbeing and a track record of success to Mountain View students at Khan Lab (Middle & Upper) School.	
Program Delivery Site(s)	• Mountain View High School, 3535 Truman Ave, Mountain View, CA 94040 • Los Altos High School, 201 Almond Ave, Los Altos, CA 94022 • Alta Vista High School, 1325 Bryant Ave, Mountain View, CA 94040 • Khan Lab School (Middle & Upper School), 1200 Villa Street, Mountain View, CA 94041	
Services Funded By Grant	• Individual therapy sessions, typically weekly for approximately twelve weeks, 30 minutes for elementary and 45 minutes for middle and high school • Group counseling sessions, typically weekly for approximately 4-8 weeks • Check-ins with students who need emotional regulation or resources but are not in therapy • Crisis interventions and risk assessments as needed • Weekly meetings with school staff to coordinate care of student population • Classroom presentations on topics agreed upon by CASSY and the school depending on emerging issues • Parent presentations as requested by the school parent organization • Consultations with parents/caregivers and school staff to support student wellness • Training school staff on topics requested by the school (recognizing red flags, CPS reporting requirements, etc.) • Conducting school activities and attending school meetings to increase awareness of CASSY services • Wellness center coverage to support student walk-ins as requested by school	
Budget Summary	Full requested amount funds partial salaries and benefits for school-based therapists, clinical program manager, program management/quality assurance, administrator and development manager as well as some facilities costs, program supplies, training/fees and administrative overhead.	
FY2026 Funding	FY2026 Requested: $29,600	FY2026 Recommended: DNF

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Counseling and Support Services for Youth

[Continued from previous page]

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New program in FY2026	New program in FY2026	New program in FY2026

	Metrics	***6-month Target***	***Annual Target***
FY2026 Proposed Metrics	Individuals served	140	210
	Services provided	1,330	2,660
	Number of hours of counseling/care management sessions provided to youth	1,330	2,660
	Students who work directly with CASSY therapists will stabilize or show an increase in prosocial behaviors/decrease in antisocial behaviors, according to the vetted assessment tool called the Pediatric Symptom Checklist (PSC).	85%	85%
	Students and their parents will declare CASSY services met their clinical needs and would recommend CASSY services to their peers and/or other parents as measured by scoring at least 3 out of 5 on a direct survey completed at the end of treatment.	85%	85%

FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Cupertino Union School District – Two Year Application

Program Title	Mental Health Counseling Program	***Recommended Amount:*** $102,500
Program Abstract & Target Population	Mental health therapist provides individual and group counseling, crisis intervention, socially facilitated activities, social and emotional learning lessons and support to students at Nimitz Elementary in Sunnyvale.	
Agency Description & Address	10301 Vista Drive Cupertino, CA 95014 https://www.cusdk8.org/ Located in the heart of Silicon Valley, Cupertino Union School District (CUSD) is a Local Education Agency providing public education and consistently ranking amongst the top performing elementary (TK-8th) school districts in California. The largest elementary school district in northern California, CUSD is comprised of nearly 1,400 employees serving approximately 13,500 students in 17 elementary schools, one K-8 school, and five middle schools located through Cupertino and parts of Sunnyvale, San Jose, Saratoga, Los Altos, and Santa Clara. The mission of CUSD focuses on relevant and rigorous instruction, personalized learning, and a whole-child approach to preparing our students for success. District families and staff join as partners to develop creative, exemplary learners with the skills and enthusiasm to contribute to a constantly changing global society.	
Program Delivery Site(s)	• Nimitz Elementary, 545 East Cheyenne Drive, Sunnyvale, CA 94087	
Services Funded By Grant	• Individual counseling sessions that typically run 30-60 minutes weekly • Group counseling 6–10-week sessions for 30-50 minutes (topics such as social skills, friendship skills, executive functioning, emotional regulation, mindfulness, and self-esteem/empowerment) • Check-in, that is typically 15 minutes and is a maintenance session between scheduled appointments to provide extra support • Lunch Bunch/Social Group experiences, socially facilitated activities during the play/free time of the lunch break for approximately 30-40 minutes, drop in or teacher referred • Crisis intervention/Safety Risk Assessments (for suicidality, self-harm, and other high-risk behaviors), as needed • Social and Emotional Learning lessons, 30–45-minute support sessions, as needed	
Budget Summary	Full requested amount funds a portion of a mental health therapist salary and benefits, some training costs and some counseling supplies.	
FY2026-FY2027 Funding	FY2026 Requested: $112,000 ($224,000 over two years)	FY2026 Recommended: $102,500 ($205,000 over two years)

	FY2025	FY2024	FY2023
Funding History & Metric Performance	FY2025 Approved: $102,500 FY2025 6-month metrics met: 55%	FY2024 Approved: $102,500 FY2024 Spent: $102,500 FY2024 Annual metrics met: 78%	FY2023 Approved: $93,000 FY2023 Spent: $93,000 FY2023 Annual metrics met: 98%
FY2026 Dual Funding	FY2026 Requested: $132,000	FY2026 Recommended: $130,000	
Dual Funding History & Metric Performance	FY2025 Approved: $130,000 FY2025 6-month metrics met:100%	FY2024 Approved: $130,000 FY2024 Spent: $130,000 FY2024 Annual metrics met:84%	FY2023 Approved: $120,000 FY2023 Spent: $120,000 FY2023 Annual metrics met:100%

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FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Cupertino Union School District

[Continued from previous page

	Metrics	6-month Target	Annual Target
FY2026-FY2027 Proposed Metrics	Individuals served	75	250
	Services provided	150	300
	Number of hours of counseling/care management sessions provided to youth	75	150
	Improvement on the Strengths Difficulties Questionnaire (SDQ) pre to post test by 3 points	0%	50%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Fremont Union High School District

Program Title	Homestead High School Wellness Space	***Recommended Amount:*** DNF
Program Abstract & Target Population	Wellness space support specialist at Homestead High School determines the presenting need of the student, supports wellness activities and facilitates a referral to a school-based therapist, as appropriate. The long-term impact of a wellness space is a reduction in the need for intensive care through a coordinated program that provides early intervention, activities, and individual and group counseling.	
Agency Description & Address	589 West Fremont Avenue Sunnyvale, CA 94087 https://www.fuhsd.org The Fremont Union High School District (FUHSD) is home to five comprehensive sites, Educational Options and Adult School. The district prides itself on the holistic focus of programs providing students with a variety of opportunities for academic achievement, elective courses, extracurricular activities and athletics.	
Program Delivery Site(s)	• Homestead High School, 21370 Homestead Road, Cupertino, CA 95014	
Services Funded By Grant	• The Specialist is dedicated to supporting the emotional and mental well-being of all students and serve as a liaison between the Wellness Space, students, parents, school site staff, and district personnel: o confer with school personnel, district administration, and others concerning students; o link students, parents, and families to district resources for community based and social services; o participate as a member of the school site mental health team; o collaborate with the student advisory board; o establish and maintain Wellness Space activities, including the incorporation of school clubs and community-based organizations; o create outreach opportunities, posters, and flyers, and contribute to newsletters within the site and district; and o compile data as part of monitoring student access to and participation within the space.	
Budget Summary	Full requested amount funds the wellness space support specialist position salary and benefits.	
FY2026 Funding	FY2026 Requested: $132,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New program in FY2026	New program in FY2026	New program in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	200	400
	Services provided	500	1,000
	Number of youth demonstrating improvement on treatment plan goals	190	380
	Students who report a 2-point increase from check-in to check-out on a 10-point scale.	95%	95%

FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Los Altos School District – Two Year Application

Program Title	Mental Health Counseling Program	***Recommended Amount:*** $150,000
Program Abstract & Target Population	Licensed mental health therapist provides individual, group, and family counseling, crisis intervention and case management, as well as social activities and social emotional learning for middle school students in Los Altos School District.	
Agency Description & Address	201 Covington Road Los Altos, CA 94024 www.lasdschools.org Los Altos School District (LASD) operates seven elementary and two junior high schools and is a top-rated school district in the State of California. LASD serves TK-8 students from portions of Los Altos, Los Altos Hills, Mountain View, and Palo Alto and prepares all TK-8 students to thrive in our rapidly changing global community. All nine schools in the district are California Distinguished Schools and/or National Blue Ribbon Schools. LASD is nationally recognized for its many educational innovations and awards	
Program Delivery Site(s)	• Blach Intermediate School: 1120 Covington Rd, Los Altos, CA 94024 • Egan Junior High School: 100 W Portola Ave, Los Altos, CA 94022	
Services Funded By Grant	• Individual therapy includes one-on-one sessions, group therapy, and therapeutic check-ins, ranging from 10 to 45 minutes. • Group counseling (2–8 students) focuses on identity, peer relationships, and anxiety management, lasting 8–12 weeks with 30–45-minute sessions. • Family therapy involves parent/guardian meetings to address student and family needs (30–45 minutes). • Crisis intervention includes suicide assessments, de-escalation, problem-solving, and CPS reporting, lasting 45 minutes to 4 hours. • Case management ensures collaboration with teachers, parents, and external providers. • Classroom interventions promote emotional regulation and resiliency through lunchtime clubs and activities. • Teacher/staff Support and consultation assists educators through short-term counseling, referrals, social emotional learning and district collaboration.	
Budget Summary	Full requested amount funds 1 FTE mental health therapist's salary and benefits.	
FY2026-FY2027 Funding	FY2026 Requested: $173,000 ($346,000 over two years)	FY2026 Recommended: $150,000 ($300,000 over two years)

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $150,000 FY2025 6-month metrics met: 87%	FY2024 Approved: $150,000 FY2024 Spent: $150,000 FY2024 Annual metrics met:100%	FY2023 Approved: $130,000 FY2023 Spent: $130,000 FY2023 Annual metrics met: 75%

FY2026-FY2027 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	100
	Services provided	450	1,000
	Number of hours of counseling/care management sessions provided to youth	200	400
	Students who improve by at least 3 points from pre-test to post-test on the 40-pt. scale (SDQ) based upon self-report.	N/A	50%

FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Mountain View-Los Altos Union High School District – Two Year Application

Program Title	MVLA School-based Mental Health and Case Management Services	***Recommended Amount:*** $220,000
Program Abstract & Target Population	Licensed social worker provides intake screening, check-ins, follow-up/drop-in, crisis intervention, case management, transition back to school from hospitalization/extended absences due to mental health issues, IEP meetings, as well as family and clinical consultation for students of the Mountain View-Los Altos Union High School District.	
Agency Description & Address	1299 Bryant Avenue Mountain View, CA 94040 http://www.mvla.net Serving the communities of Mountain View, Los Altos and Los Altos Hills, the MVLA district is comprised of two comprehensive high schools, an alternative high school, an adult education center, the Freestyle Academy for Arts & Technology, and Middle College. MVLA is committed to providing learning and growth opportunities so each of the 4,539 students can reach their full potential.	
Program Delivery Site(s)	• Mountain View High School, 3535 Truman Ave. Mountain View, CA 94040 • Los Altos High School, 201 Almond Ave., Los Altos, CA 94022	
Services Funded By Grant	• Youth Counseling/Care Management Sessions o Check-in / Follow-up - Duration is typically 15 to 60 min. in length and focuses primarily on regulating behaviors, emotions, or cognitions. o Drop-in Services - Duration is typically 15 to 60 min. in length and focuses primarily on regulating behaviors, emotions, or cognitions. o Crisis Intervention - Duration typically ranges from 90 min. to 4 hours and often requires follow-up case-management. • Case Management Services o Intake Screening - Duration ranges from 30 to 60 min. o Circle of Care Meeting (Transitioning Back to School Meeting) -Duration ranges from 30 to 60 min. o SAT/SST Meeting - Duration ranges from 30 to 60 min. o IEP Meeting - Duration ranges from 45 to 60 min. o Family Consultation - Duration ranges from 30 to 60 min. o Clinical Consultation - Duration ranges from 15 to 60 min.	
Budget Summary	Full requested amount funds a portion of a licensed social worker salary.	
FY2026-FY2027 Funding	FY2026 Requested: $231,000 ($462,000 over two years)	FY2026 Recommended: $220,000 ($440,000 over two years)

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $220,000 FY2025 6-month metrics met: 71%	FY2024 Approved: $220,000 FY2024 Spent: $220,000 FY2024 Annual metrics met: 78%	FY2023 Approved: $210,000 FY2023 Spent: $210,000 FY2023 Annual metrics met: 38%

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FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Mountain View-Los Altos Union High School District

[Continued from previous page]

	Metrics	6-month Target	Annual Target
FY2026-FY2027 Proposed Metrics	Individuals served	150	275
	Services provided	200	350
	Number of hours of counseling/care management sessions provided to youth	150	300
	Students Connected to Services: Percentage of Patients (Students) Enrolled in a Clinical or Community Service based on the presenting issue.	75%	75%

FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Pacific Clinics – Two Year Application

Program Title	School Based Intervention Teams (SBIT)	***Recommended Amount:*** $304,000
Program Abstract & Target Population	Clinical supervisor and therapists provide individual and group counseling, social emotional learning lessons, psycho-ed groups, caregiver/teacher coaching, crisis intervention, case management and IEP meetings for elementary students and staff at 10 schools in the Sunnyvale Elementary School District.	
Agency Description & Address	499 Loma Alta Avenue Los Gatos, CA 95030 www.pacificclinics.org Pacific Clinics (PC) is a private nonprofit agency that is the largest, most comprehensive behavioral healthcare agency in California. We take a state-of-the-art approach to serving individuals with complex behavioral health challenges by providing research-informed and community-based services to address individualized needs. PC is accredited by the Council on Accreditation (COA) and serves more than 25,000 individuals annually in 24 counties throughout California. PC's dedicated team of 2,000 employees is fluent in over 22 languages. They aim to deliver integrated behavioral health care and social services to advance health equity and mental well-being for children, adults, and families.	
Program Delivery Site(s)	• Bishop Elementary, 450 N Sunnyvale Ave, Sunnyvale, CA 94085 • Cherry Chase Elementary, 1138 Heatherstone Way, Sunnyvale, CA 94087 • Cumberland Elementary, 824 Cumberland Dr. Sunnyvale, Ca 94087 • Ellis Elementary, 550 E Olive Ave, Sunnyvale, CA 94086 • Fairwood Elementary, 1110 Fairwood Ave, Sunnyvale, CA 94089 • Lakewood Elementary, 750 Lakechime Dr, Sunnyvale, CA 94089 • San Miguel Elementary, 777 San Miguel Ave, Sunnyvale, CA 94085 • Vargas Middle School, 1054 Carson Dr, Sunnyvale, CA 94086 • Columbia Middle School, 739 Morse Ave, Sunnyvale, CA 94085 • Sunnyvale Middle School, 1080 Mango Ave, Sunnyvale, CA 94087	
Services Funded By Grant	• Social-Emotional Learning Programs for targeted grades in full classrooms, teaching social emotional regulation skills, for 4-8 sessions. • Behavior Intervention: Evidenced-based 1:1 or Group Behavioral Intervention. (short term) • Restorative practice and Wellness services: Short term 1:1 or Groups for alternatives to suspension. • Psycho-ed Groups: Groups of 4-6 students with defined topics, weekly for up to 8 sessions. • Caregiver/Teacher Coaching focused on the needs of the student. • Mono-Lingual Translation: Meetings with caregivers requiring a linguistically competent, second PC staff. • Crisis intervention: Risk assessments, care-team collaboration, de-escalation of students in crisis with problem solving, and Child Protective Services reporting. Followed by Management. • Case management: Interactions with administrators/teachers, outside professionals. Includes Individual Education Plan meetings. • Documentation: Clinical documentation, training on Electronic Health Record system. • Duration ranges from 30-45 minutes for direct services (Ind., SEL, Groups) and 15 minutes to a few hours for Indirect services. Measured by hours, rounded to the quarter hour	

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FY2026-FY2027 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Pacific Clinics

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Budget Summary	Full requested amount funds associate educational clinical coordinators, educational behavioral specialist, and program manager/supervisor partial salaries and benefits as well as some facilities expenses, program supplies costs and administrative overhead.		
FY2026-FY2027 Funding	FY2026 Requested: $340,000 ($680,000 over two years)	FY2026 Recommended: $304,000 ($608,000 over two years)	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $304,000 FY2025 6-month metrics met: 51%	FY2024 Approved: $304,000 FY2024 Spent: $304,000 FY2024 Annual metrics met: 98% *Provided by CHAC*	FY2023 Approved: $280,000 FY2023 Spent: $280,000 FY2023 Annual metrics met: 95% *Provided by CHAC*

FY2026-FY2027 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	125	215
	Services provided	400	800
	Number of hours of counseling/care management sessions provided to youth	200	400
	Students who improve by at least 1 point from pre-test to post-test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on self-report (for students age 11-17).	N/A	50%
	Students who improve by at least 1 point from pre-test to post test on the 40-point scale Strengths and Difficulties Questionnaire and Impact Assessment based on teacher report for ages 10 and under.	N/A	50%

FY2026-FY2027 Chronic Conditions Application Summary

Chronic Conditions
(Other than Diabetes & Obesity)

Community Services Agency of Mountain View, Los Altos, and Los Altos Hills – Two Year Application

Program Title	Senior Services Intensive Case Management Program	***Recommended Amount:*** $326,600
Program Abstract & Target Population	Social worker, registered nurse, and licensed vocational nurse provide post-discharge intensive case management for seniors with chronic conditions at the CSA, in clients' homes, and at medical offices. The target population is low-income adults 55 years of age and older who live in their own independently (non-institutionalized setting) in the El Camino Healthcare District and have at least one chronic health condition that puts them at risk for hospitalization.	
Agency Description & Address	204 Stierlin Road Mountain View, CA 94043 http://www.csacares.org Community Services Agency provides a safety net for elderly, low-income, and unhoused residents of Mountain View, Los Altos and Los Altos Hills. They offer nutrition services, shopping assistance, and case management for seniors; food and emergency financial aid for low-income individuals; and comprehensive case management for unhoused individuals and families. The services are local, direct, and personal and our staff and volunteers constantly seek to improve our clients' stability, self-reliance, and dignity. CSA's strong community partnerships offer local residents many different ways to give of their time, money, goods, and services to benefit their disadvantaged neighbors.	
Program Delivery Site(s)	• Community Services Agency, 204 Stierlin Rd., Mountain View, CA 94043 • Community Services Agency Senior Services building, 1012 Linda Vista Ave., Mountain View, CA 94043 • Client homes that are located in El Camino Healthcare District, medical offices and hospitals	
Services Funded By Grant	• 60–90-minute bio-psycho-social assessment at time of intake • Education on health conditions and how to manage them, as needed; approximately 30-60 minutes/session • Follow-up phone calls and assistance with scheduling medical appointments as needed; estimated 15-30 minutes per phone call • Advocacy at medical appointments as needed; approximately 60-120 minutes per appointment • Medication reconciliation and evaluation at time of initial intake and as needed • Fall risk assessment every year, with targeted interventions to address fall risk concerns • Home safety evaluation at the time of initial intake and as needed • Financial assistance for medication as needed • Assistance signing up for county/state benefits and services; approximately 30-60 minutes per meeting • Coordination with client's medical team, family, and/or friends as needed • Education and referrals, as needed until graduation from program	
Budget Summary	Full requested amount funds a social worker and registered nurse case managers salary and a portion of a licensed vocational nurse case manager and program director salaries and a portion of all the program staff's benefits and other program costs and administrative overhead.	

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FY2026-FY2027 Chronic Conditions Application Summary

Community Services Agency of Mountain View, Los Altos, and Los Altos Hills

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FY2026-FY2027 Funding	FY2026 Requested:	$326,630 ($653,260 over two years)	FY2026 Recommended:	$326,600 ($653,200 over two years)
Funding History & Metric Performance	FY2025	FY2024	FY2023	
	FY2025 Approved: $240,000 FY2025 6-month metrics met: 86%	FY2024 Approved: $240,000 FY2024 Spent: $240,000 FY2024 Annual metrics met: 94%	FY2023 Approved: $228,000 FY2023 Spent: $203,195 FY2023 Annual metrics met:100%	
FY2026-FY2027 Proposed Metrics	***Metrics***		***6-month Target***	***Annual Target***
	Individuals served		60	110
	Services provided		2,900	5,600
	Number of individuals completing one or more health screenings		60	110
	Participants report maintaining original score or a 1-point reduction in the nutritional assessment (on a scale of 1 to 21).		52%	85%
	Participants report maintaining original score or a 1-point decrease in the fall risk assessment (on a scale of 1 to 15).		35%	65%

FY2026-FY2027 Economic Stability Application Summary

Sunnyvale Community Services – Two Year Application

Program Title	Social Work Case Management/Homebound Case Management	***Recommended Amount:*** $266,900	
Program Abstract & Target Population	Social worker and homebound case managers and a food/nutrition coordinator provide case management for vulnerable populations specifically addressing the needs of seniors and individuals with disabilities who experience difficulty leaving their homes.		
Agency Description & Address	1160 Kern Avenue Sunnyvale, CA 94085 http://www.svcommunityservices.org Since 1970, Sunnyvale Community Services (SCS) has been dedicated to preventing homelessness and hunger. As one of Santa Clara County's seven Emergency Assistance Network (EAN) agencies, SCS is a safety net hub for underserved residents. SCS is the primary EAN agency for all zip codes in Sunnyvale, and practice "no wrong door" to connect any County residents to basic services. SCS offers low-income families and individuals' access to healthy food, financial assistance, health care and other benefit referrals, and wrap-around case management. SCS hosts dozens of partner agencies for "one-stop" access to medical, legal, educational, and financial resources, helping residents to access the support they are entitled to receive, and building a path to stability so they can thrive in our community.		
Program Delivery Site(s)	• 1160 Kern Avenue, Sunnyvale CA 94085 • Clients homes as needed		
Services Funded By Grant/How Funds Will Be Spent	• Initial intake assessing the client's needs • Development of a case plan for each household, with specified goals • Frequent follow-on meetings (often weekly) and quarterly assessments • As needed, accompaniment to medical or legal appointments • Monthly monitoring checks (by telephone or in person) • Assistance and advocacy with applications for access to health care, nutrition programs, affordable housing, education, job training, employment, childcare, financial education, budgeting, and resource referrals • Care coordination • Referrals to public benefits • Access to financial management and health- and nutrition-related services sponsored and/or delivered by SCS, targeted to meet specific client needs, including nutrition evaluation and recommendations by SCS' Food and Nutrition Program team. • Access to low-cost monthly bus passes and free Clipper cards		
Budget Summary	Full requested amount funds a social work case manager, homebound case manager and food/nutrition coordinator full salaries and benefits, and interpretation support as well as administrative overhead.		
FY2026-FY2027 Funding	FY2026 Requested:	$266,938 ($533,876 over two years)	FY2026 Recommended: $266,9000 ($533,800 over two years)

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FY2026-FY2027 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Sunnyvale Community Services

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Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $207,000 FY2025 6-month metrics met: 98%	FY2024 Approved: $207,000 FY2024 Spent: $207,000 FY2024 Annual metrics met: 94%	FY2023 Approved: $197,000 FY2023 Spent: $197,000 FY2023 Annual metrics met: 93%

	Metrics	***6-month Target***	***Annual Target***
FY2026-FY2027 Proposed Metrics	Individuals served	325	550
	Services provided	3,250	6,500
	Number of individuals with improved living conditions as a result of services provided	325	550
	Case management clients whose scores on the Step Up Silicon Valley Self-Sufficiency Measure or comparable tool reach or maintain a score of 3.0 or higher six months after entering program	70%	70%
	Homebound case management clients referred to benefits and services they are entitled to receive	70%	70%

FY2026-FY2027 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Sunnyvale Community Services – Two Year Application

Program Title	Comprehensive Safety Net Services	***Recommended Amount:*** $131,700
Program Abstract & Target Population	Emergency financial assistance to low-income families and individuals at risk of eviction due to the financial strain caused by medical conditions and food/meal delivery for homebound low-income residents in danger of eviction.	
Agency Description & Address	1160 Kern Avenue Sunnyvale, CA 94085 http://www.svcommunityservices.org Since 1970, Sunnyvale Community Services (SCS) has been dedicated to preventing homelessness and hunger. As one of Santa Clara County's seven Emergency Assistance Network (EAN) agencies, SCS is a safety net hub for underserved residents. SCS is the primary EAN agency for all zip codes in Sunnyvale, and practice "no wrong door" to connect any County residents to basic services. SCS offers low-income families and individuals' access to healthy food, financial assistance, health care and other benefit referrals, and wrap-around case management. SCS hosts dozens of partner agencies for "one-stop" access to medical, legal, educational, and financial resources, helping residents to access the support they are entitled to receive, and building a path to stability so they can thrive in our community.	
Program Delivery Site(s)	• 1160 Kern Avenue, Sunnyvale CA 94085 • Clients homes as needed	
Services Funded By Grant/How Funds Will Be Spent	• Emergency financial aid for medically related bills or for rent assistance and housing related bills, which then allows individuals to pay their medically related bills • Financial aid for medically related equipment such as wheelchairs, walkers, ramps, medical beds, grab bars and other resources • Healthy nutritious groceries, selected to meet the unique nutrition and preparation needs of individuals who are battling medical or health issues, and ready-to-eat meals, when available, delivered to program participants twice monthly	
Budget Summary	Full requested amount funds emergency financial aid for low-income clients at risk of eviction who have experienced an unexpected medical emergency expense including medically related equipment, as well as funding for twice-monthly nutritious grocery/meal deliveries to homebound households.	
FY2026-FY2027 Funding	FY2026 Requested: $131,750 ($263,500 over two years)	FY2026 Recommended: $131,700 ($263,400 over two years)

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $75,000 FY2025 6-month metrics met: 88%	FY2024 Approved: $75,000 FY2024 Spent: $75,000 FY2024 Annual metrics met: 100%	FY2023 Approved: $75,000 FY2023 Spent: $75,000 FY2023 Annual metrics met:100%

FY2026-FY2027 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	230	325
	Services provided	2,700	5,500
	Number of individuals with improved living conditions as a result of services provided	230	325
	Individuals receiving financial assistance for medically related bills, or for rent assistance and housing related bills which then allows them to pay their medically related bills, who are still housed 60 days after assistance, if individual is not homeless when assisted.	90%	90%
	Individuals receiving home delivery food assistance reporting groceries and prepared meals meet their individual dietary and preparation challenges.	85%	85%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

AnewVista Community Services

Program Title	Equal access to Information & Resources; Enhancing Seniors' Quality of Life	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Instructors will assist seniors in learning how to navigate online health platforms and apps confidently on their own, via in-person and virtual instruction.	
Agency Description & Address	250 Hillview Avenue Redwood City, CA 94062 www.anvcs.org Equal access to Information and Resources. Enhancing Seniors' Quality of Life. AnewVista Community Services (ANVCS.org) addresses critical needs by equipping older adults with the technology skills to access healthcare and overcome social isolation, fostering a healthier and more connected community. We achieve this by building confidence through a learning journey along with regular access to experts. Our free tech-talks are in-person and online creating a hybrid community. We have provided tech talks at senior centers and facilities across the South Bay and Peninsula since 2019. Over 5 years we have built a community of 2500+ older adults. In 2024, we conducted 200+ tech-talks. Consistent schedule of tech-talks/workshops, trusted support and accessibility have been key to helping older adults overcome social isolation and reduce their vulnerability.	
Program Delivery Site(s)	• Los Altos Senior Center • Mountain View Senior Center • Cupertino Senior Center • Sunnyvale Senior Center • Los Altos Hills Senior Center • ICC - Senior Center(Cupertino)	
Services Funded By Grant	With the funding from ECHD: • ANVCS.org will conduct FREE in-person tech-talks/workshops for older adults at each of the 5 Senior Centers within ECHD area. • ANVCS.org will provide 1-hour FREE online tech-talks/classes for older adults on average, 3-4 times/week. (~150 online tech-talks per year) • Each tech-talk is attended on average by 30 older adults • Tech-talks/workshops are primarily provided in English but also include twice-a-month classes in Spanish and sometimes in Hindi • Each class is a 1-hour session is focused on a specific topic and we have a catalog of 150+ topics (https://www.anvcs.org/grants) • Email Weekly Newsletters • Create and Share Micro Learning Blogs, Reels on Health Topics o Examples - Online Health: Health Apps; Hearing Aids/Bluetooth; Wearables/Fall Detection Devices, My Chart • Our Free live tech classes provide a source of trusted support system and gives them the confidence in navigating the online health resources.	
Budget Summary	Full requested amount funds Instructors, Marketing & Community Engagement Personnel, Operations Personnel as well as some costs for facilities/utilities, printing supplies, software licenses, training and administration overhead.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

AnewVista Community Services

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Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $20,000 FY2025 6-month metrics met: 96%	New Program in FY2025	New Program in FY2025

	Metrics	***6-month Target***	***Annual Target***
FY2026 Proposed Metrics	Individuals served	200	400
	Services provided	400	900
	Number of individuals enrolled in a clinical and/or community service based on needs identified by their navigator/care manager	400	900

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

El Camino Health

Program Title	El Camino Health, Health Library & Resource Center, Mountain View	***Recommended Amount:*** $175,000
Program Abstract & Target Population	Medical Librarian and Coordinator staff services to improve health literacy and knowledge of care options for patients, families, and caregivers at the Health Library & Resource Center in Mountain View.	
Agency Description & Address	2500 Grant Road Mountain View, CA 94040 https://www.elcaminohealth.org/community/health-library-resource-center The Health Library & Resource Center (HLRC) provides access to high quality vetted information tailored to the information needs of each individual patron. Information is available in various formats including medical subscription databases, journals, clinical textbooks, and consumer-oriented resources. The HLRC provides research assistance, Eldercare Counseling, Medicare Counseling and appointments with the dietitian and pharmacist. Many patrons receive information by telephone or email or by visiting the HLRC.	
Program Delivery Site(s)	• El Camino Health, Health Library & Resource Center, 2500 Grant Road, Mountain View, CA 94040	
Services Funded By Grant	• Funds to purchase updated books, database subscriptions, journals and catalogue and make these resources available and assist patrons in using the library materials. • Telephone assistance to answer various questions from the community • Walk in assistance • Online research assistance • Online library http://www.elcaminohealth.org/library • Advance Health Care Assistance • Consultations with the Dietitian • Consultations with the Pharmacist • Consultations with the Medicare Counselor • Families can receive assistance in caring for their aging parents or loved ones through the resource center's eldercare consultation service.	
Budget Summary	Full requested amount funds partial salaries and benefits for medical librarian, coordinator, program supplies and purchased services.	
FY2026 Funding	FY2026 Requested: $175,000	FY2026 Recommended: $175,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $175,000 FY2025 6-month metrics met:100%	FY2024 Approved: $175,000 FY2024 Spent: $149,352 FY2024 Annual metrics met:100%	FY2023 Approved: $175,000 FY2023 Spent: $137,640 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	4,000	8,000
	Services provided	4,000	8,000
	Library services have been valuable in helping me manage my health or that of a friend or family member	80%	80%
	Library information is appropriate to my needs	90%	90%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

El Camino Health

Program Title	RoadRunners Transportation Program	***Recommended Amount:*** $165,000
Program Abstract & Target Population	Funding for Transportation Supervisor and Department Assistant, in addition to vehicle operating costs, Lyft supplemental support and software costs, to provide healthcare transportation service for seniors and disabled community members to medical facilities within the El Camino Healthcare District.	
Agency Description & Address	530 South Drive Mountain View, CA 94040 https://www.elcaminohealth.org/community/roadrunners-transportation The El Camino Health RoadRunners Transportation program is a community-based transportation service that is available to ambulatory clients and patients, specializing in seniors and the disabled who are unable to drive. The Roadrunners program has a close working relationship with community physicians, community clinics, local Community Services agencies, as well as other medical facilities within the district. Unfortunately, a growing number of seniors who are no longer able to drive may face isolation and loneliness in addition to limited access to medical care and may not even know what community services and resources are available.	
Program Delivery Site(s)	• Behavior Health • Cancer Center • Community Centers • Hospital • Senior Centers • Medical Clinics	
Services Funded By Grant	RoadRunners drive senior residents to medical appointments, Seniors Centers, Banks, Grocery Stores and to various other location in the community within a 10-mile radius of El Camino Health. In addition, through the on-demand Transportation partner with Lyft, they provide rides in a convenient and flexible service to other areas.	
Budget Summary	Full requested amount funds transportation supervisor, department assistant and purchased services, repairs/maintenance, supplies and other operating costs.	
FY2026 Funding	FY2026 Requested: $165,000	FY2026 Recommended: $165,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $165,000 FY2025 6-month metrics met: 97%	FY2024 Approved: $165,000 FY2024 Spent: $161,500 FY2024 Annual metrics met: 89%	FY2023 Approved: $165,000 FY2023 Spent: $149,936 FY2023 Annual metrics met: 97%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	325	650
	Services provided	3,500	7,000
	Number of individuals receiving follow-up care after a health screening	800	1,600

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

El Camino Health

Program Title	ECHD Population Health Program Manager	***Recommended Amount:*** $247,000
Program Abstract & Target Population	Program manager will develop a foundation for identifying and intervening to improve the health of "rising-risk" patients who live, work, or go to school within the El Camino Healthcare District through offering a comprehensive suite of programs and wraparound services to support ECHD constituents in preventing and managing an array of chronic diseases and wraparound services focused to support ECHD constituents with Prediabetes management.	
Agency Description & Address	2500 Grant Road Mountain View, CA 94040 https://www.elcaminohealth.org/ El Camino Health provides a personalized healthcare experience at two nonprofit acute care hospitals in Los Gatos and Mountain View, and at primary care, multi-specialty care and urgent care locations across Santa Clara County. For sixty years, the organization has grown to meet the needs of the individuals and communities, it serves. Bringing together the best in new technology and advanced medicine, the network of nationally recognized physicians and care teams deliver high-quality, compassionate care. Key medical specialties include cancer, heart and vascular, mental health and addiction services, mother-baby health, and lifestyle medicine.	
Program Delivery Site(s)	• El Camino Health Mountain View, 2500 Grant Road, Mountain View, CA 94040	
Services Funded By Grant	• Develop a high-level Population Health Profile to inform baseline measurement of the health of the community as well as provide foundation for the 1-3+ year Population Health Strategy • Develop a measurement framework for the prediabetes work, taking into consideration the "contribution, not attribution" approach • In partnership with Community Benefit, develop a 1-3+ year Population Health Strategy that includes our approach to a vendor/app-based prediabetes solution along with wraparound services to meet people where they are at in terms of prediabetes intervention • Partner with Community Partnerships on tactical execution of vendor/app-based solution and design of ancillary programs. • Facilitate partner meetings, own structure of meetings and timeline of deliverables, track progress, etc.	
Budget Summary	Full requested amount funds program manager salary and benefits as well as program supplies, contracted services, training/education and travel.	
FY2026 Funding	FY2026 Requested: $247,000	FY2026 Recommended: $247,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $247,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $189,000 FY2024 Spent: $80,655 FY2024 Annual metrics met: 0%	New Program in FY2024

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	150	150
	Services provided	150	150
	Number of individuals who report 150 minutes or more of physical activity per week	50	100
	Self reported improvement in nutrition and exercise	50%	50%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

El Camino Health

Program Title	Health Care Navigation Specialist	***Recommended Amount:*** $150,000
Program Abstract & Target Population	Health care navigator provides assistance with securing housing, food security, transportation, mental health support, and follow-up care with primary healthcare providers by connecting patients with local resources. The primary beneficiaries of this program are patients who face barriers to care following hospital discharge, particularly those affected by social determinants of health who are screened and assessed by either the RN case manager or MSW social worker during hospital admission and live within ECHD.	
Agency Description & Address	2500 Grant Road Mountain View, CA 94040 https://www.elcaminohealth.org/patients-visitors/guide/while-youre-here/patient-resources/care-coordination El Camino Health has several times been designated a nursing magnet hospital by the American Nursing Credentialing Center. Specialties include acute rehabilitation, cardiac care, dialysis, cancer care, maternal child health services, orthopedics, neurosurgery and behavioral health. The hospital has 420 beds in Mountain View and a second smaller hospital (about 50 beds) in Los Gatos. The care coordination department supports patients with care transitions and discharge planning.	
Program Delivery Site(s)	• Services are primarily offered at 2500 Grant Road Mountain View CA 94040 and typically patients can expect to be contacted by telephone for follow up support after discharge	
Services Funded By Grant	• Outreach Calls: 7-8 daily outreach calls, totaling 1,410 calls annually, to connect patients with community resources and ensure follow-up care. • Case Management: One-on-one case management sessions with health care navigator to assess needs and provide support in areas such as housing, transportation, and food security. • Partner Agency Collaboration: Coordination with agencies specializing in healthcare access, behavioral health, chronic conditions, and SDOH (housing, economic stability) to ensure comprehensive patient support. • Quarterly Convenings: Regular quarterly meetings with community benefit partners (grant recipients) to enhance collaboration, share resources, and streamline care coordination. • Chronic Condition Management: Referrals to programs for managing diabetes, obesity, and other chronic conditions, including care coordination and education. • Behavioral Health Support: Referrals to mental health services, counseling, and behavioral health programs as needed post-discharge. • These services will address both medical and social needs to improve patient outcomes.	
Budget Summary	Full requested amount funds health care navigator salary and benefits.	
FY2026 Funding	FY2026 Requested: $150,000	FY2026 Recommended: $150,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $150,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $150,000 FY2024 Spent: $19,719 FY2024 Annual metrics met:46%	FY2023 Approved: $150,000 FY2023 Spent: $79,463 FY2023 Annual metrics met: 17%

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

El Camino Health

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	120	240
	Services provided	650	1,300
	Number of individuals enrolled in a clinical and/or community service based on needs identified by their navigator/care manager	120	240
	Percentage of patients successfully connected to at least one community resource following navigator outreach. 85% of patients will be successfully linked to at least one community resource within 30 days of program enrollment.	85%	85%
	Percentage of patients who complete the navigator support process and transition to sustainable community follow-up care.	75%	75%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Health Mobile

Program Title	Free Comprehensive dental treatments for low-income, senior and homeless population of Mountain View and Sunnyvale	***Recommended Amount:*** $50,000
Program Abstract & Target Population	Dentist and clinic staff provide comprehensive mobile dental services to low-income families, seniors, and homeless individuals in Sunnyvale and Mountain View.	
Agency Description & Address	1659 Scott Boulevard #4 Santa Clara, CA 95050 www.healthmobile.org Health Mobile is a nonprofit organization providing free, comprehensive, onsite, healthcare services for the underserved population of Northern California since 1999. They provide comprehensive dental care and primary medical services in our state-the-art mobile clinics. Their mobile clinics are complete dental and primary medical clinics on the wheels.	
Program Delivery Site(s)	• Will provide free dental care to homeless population on the first and third Wednesdays at CSA-MVLA. • Will provide free dental care to free lunch program students in Mountain View and Sunnyvale during the school hours and to their parents after the school hours. • Will provide free dental care to seniors at Mountain View Senior center and Sunnyvale Senior center.	
Services Funded By Grant	• Dental Exam; 20 minutes for children 30 minutes adults, by a dentist, twice a year. • Full mouth X-ray: 20 minutes, Registered Dental Assistant (RDA), Once a year. • Dental Cleaning: 30 minutes children, 45 minutes adults dentist, twice a year. • Oral Cancer Screening: 10 minutes, dentist, once a year. • Oral hygiene education: 5 minutes, RDA, every visit. • Smoking cessation education: 5 minutes, RDA every visit. • Fillings: 30 minutes, dentist, every (as needed) visit. • Root Canals: 60 minutes, dentist, as needed. • Extraction: 30-60 minutes, dentist, dental assistant, as needed.	
Budget Summary	Full requested amount funds partial salaries for dentist, van driver, and clinic staff, supplies, lab expenses, and program costs associated with operating the mobile van.	
FY2026 Funding	FY2026 Requested: $150,000	FY2026 Recommended: $50,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New in FY2026	New in FY2026	New in FY2026

FY2026 Dual Funding	FY2026 Requested: $150,000	FY2026 Recommended: $60,000

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $50,000 FY2025 6-month metrics met: 99%	Did not apply in FY2024	FY2023 Approved: $75,000 FY2023 Spent: $75,000 FY2023 Annual metrics met: 100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	150	400
	Services provided	600	1,500
	Number of individuals reporting improved oral health after service	150	600
	Patients who report increased knowledge about their oral health	85%	85%
	Patients who report no pain after their first visit	90%	90%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

LifeMoves

Program Title	BehavioralMoves and LVN at Mountain View	***Recommended Amount:*** $160,000
Program Abstract & Target Population	LVN and BehavioralMoves programs provide individual and group counseling and health services at the agency's Mountain View Interim Housing Community for individuals experiencing homelessness. The program treats mostly adults (85%) with priority for seniors and individuals with chronic health conditions, and most are covered by Medi-Cal or Medicare, or are uninsured.	
Agency Description & Address	2550 Great America Way, Suite 201 Santa Clara, CA 95054 www.lifemoves.org LifeMoves is the largest and most innovative nonprofit organization committed to ending the cycle of homelessness for families and individuals in San Mateo and Santa Clara Counties. As a financially stable and results-driven organization, their mission, since 1987, has been to end homelessness by providing interim housing, support services, and collaborative partnerships. LifeMoves envisions thriving communities where every neighbor has a home. Last year, with over 425 employees, LifeMoves provided 7,459 homeless individuals, including hundreds of families with minor children, with food, clothing, comprehensive supportive services, and more than 543,000 nights of shelter. Most importantly, our therapeutic model is effective. Last year, 1,900 clients completing our interim shelter programs returned to stable housing.	
Program Delivery Site(s)	• Homekey Mountain View Interim Supportive Housing Community – 2566 Leghorn Street, Mountain View, CA 94043	
Services Funded By Grant	BehavioralMoves Services: • Behavioral health screenings at program entry • Individual therapy sessions (1 hour each) • Group counseling sessions (1-2 hours per week) • Trauma-informed care interventions LVN Services: • Medical screenings at intake • Chronic condition management • Medication management and adherence support • Coordination with healthcare providers	
Budget Summary	Full requested amount funds a 1.0 FTE Licensed Vocational Nurse (LVN), plus Clinical Supervision Consultants and Intern Stipends to deliver the BehavioralMoves services, as well as benefits and other admin & overhead.	
FY2026 Funding	FY2026 Requested: $160,000	FY2026 Recommended: $160,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $$160,000 FY2025 6-month metrics met: 90%	FY2024 Approved: $160,000 FY2024 Spent: $160,000 FY2024 Annual metrics met:100%	FY2023 Approved: $160,000 FY2023 Spent: $160,000 FY2023 Annual metrics met: 83%

FY2026 Dual Funding	FY2026 Requested: $50,000	FY2026 Recommended: $50,000

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $50,000 FY2025 6-month metrics met:100%	FY2024 Approved: $50,000 FY2024 Spent: $50,000 FY2024 Annual metrics met: 96%	FY2023 Approved: $50,000 FY2023 Spent: $50,000 FY2023 Annual metrics met: 98%

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

LifeMoves

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	100	200
	Services provided	350	700
	Number of individuals receiving follow-up care after a health screening	50	100
	100% of individuals will receive behavioral health screenings.	50%	100%
	85% of clients will report increased positive moods related to therapy sessions.	40%	45%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Lucile Packard Foundation for Children's Health on behalf of Lucile Packard Children's Hospital Stanford

Program Title	Stanford Medicine Children's Health Teen Van in the El Camino Healthcare District	***Recommended Amount:*** $103,000
Program Abstract & Target Population	The teen van's multi-disciplinary staff (physician, nurse practitioner, clinical social worker, and registered dietitian) provides comprehensive primary health care services including medical exams, laboratory work, nutrition counseling, and psychosocial/mental health counseling to vulnerable patients who may be uninsured, underinsured, homeless, and high-risk teens and young adults that are ages 12-25 years old at Mountain View-Los Altos High School District sites.	
Agency Description & Address	400 Hamilton Avenue, Suite 340 Palo Alto, CA 94301 www.lpfch.org Lucile Packard Children's Hospital Stanford is a nonprofit hospital in Palo Alto, devoted exclusively to the health care needs of children and expectant mothers throughout Northern California and around the world. The mission of Packard Children's is to serve our communities as an internationally recognized pediatric and obstetric hospital that advances family-centered care, fosters innovation, translates discoveries, educates health care providers and leaders, and advocates on behalf of children and expectant mothers. Lucile Packard Foundation for Children's Health is the fundraising entity for the hospital; philanthropy supports clinical care, research, and education to improve the health of children and expectant mothers, locally and worldwide. Our hospital serves as a vital safety net hospital for low-income families throughout the Bay Area and California.	
Program Delivery Site(s)	Schools in the Mountain View-Los Altos Union High School District • Los Altos High School, 201 Almond Avenue, Los Altos, CA 94022 • Alta Vista High School, 1325 Bryant Avenue, Mountain View, CA 94040 • Mountain View High School, 3535 Truman Ave, Mountain View, CA 94040	
Services Funded By Grant	• Collaborate with school administrators and staff to refer patients, give input on program activities, and provide space for social work and nutritional services • Provide immunizations, complete physical exams, sports physicals, acute illness and injury care, pregnancy tests, pelvic exams, sexually transmitted disease testing/treatment, family planning, HIV counseling/testing, health education, social services assessment and assistance, referrals to community partners, substance abuse and mental health counseling/referral, risk behavior reduction counseling, and nutrition counseling • Provide telehealth services and group sessions at our partner sites for patients most in need of counseling, stress reduction, and relaxation techniques • Provide counseling/education about the health impacts of vaping (nicotine, cannabis, or both) and other substances, and provide nicotine replacement therapy for those youth who have become dependent on nicotine through vaping or smoking tobacco • Provide naloxone to youth and their families to help prevent opioid abuse-related deaths in the community	
Budget Summary	Full requested amount funds partial salaries and benefits for medical director, social worker, dietitian, nurse practitioner, assistant manager/medical assistant, clinic assistant/medical assistant, medical assistant, registrar/driver as well as some costs for van maintenance, medical supplies and pharmaceuticals and program supplies.	

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Lucile Packard Foundation for Children's Health on behalf of Lucile Packard Children's Hospital Stanford

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FY2026 Funding	FY2026 Requested: $145,000	FY2026 Recommended: $103,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $103,000 FY2025 6-month metrics met: 95%	FY2024 Approved: $98.000 FY2024 Spent: $98,000 FY2024 Annual metrics met:100%	FY2023 Approved: $98.000 FY2023 Spent: $98.000 FY2023 Annual metrics met: 76%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	100
	Services provided	200	400
	Number of individuals receiving follow-up care after a health screening	20	40
	Unduplicated patients who undergo a social determinants of health assessment at least once annually	65%	65%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

MedCycle Network

Program Title	MedCycle Network: Medical Surplus Optimization for Underserved Communities	***Recommended Amount:*** DNF
Program Abstract & Target Population	MedCycle personnel will pick up surplus medical supplies and equipment from El Camino Health Mountain View, inventory, store and then deliver these supplies and equipment to local safety net clinics that serve individuals who are uninsured or underinsured.	
Agency Description & Address	3145 Geary Boulevard, #717 San Francisco, CA 94118 https://www.medcyclenetwork.org Our mission is to collect and redistribute high-quality, unused medical supplies to community clinics that need them most, ensuring health equity and environmental sustainability.	
Program Delivery Site(s)	• Monthly pick up of high-quality surplus medical supplies take place at the loading docks of El Camino Health, 2500 Grant Rd, Mountain View, CA 94040. • The clinics who request donated medical supplies and equipment also select which location for it to be delivered to and in what quantity as well as when. • Ravenswood Family Health Center: 1885 Bay Rd, East Palo Alto, CA 94303 • Peninsula Healthcare Connection: Opportunity Center, 33 Encina Ave, Unit 103, Palo Alto, CA 94301	
Services Funded By Grant	• Monthly surplus supply pickups from El Camino Health • Online portal for safety-net clinics to request supplies • Optimized logistics to reduce costs and carbon footprint • Impact Analytics Dashboard to track supply utilization and environmental impact • Delivery of supplies to safety-net clinics within district boundaries	
Budget Summary	Full requested amount funds pick up, inventory, storage and delivery of medical supplies and equipment, as well as partial salary of the Chief Operating Officer and some administrative overhead costs.	
FY2026 Funding	FY2026 Requested: $50,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New in FY2026	New in FY2026	New in FY2026

FY2026 Dual Funding	FY2026 Requested: $50,000	FY2026 Recommended: DNF

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	New in FY2026	New in FY2026	New in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	75,000	250,000
	Services provided	10,000	27,000
	Number of individuals receiving follow-up care after a health screening	200,000	500,000
	Reduced Stockouts: Target: 85% of clinics will report fewer stockouts of critical supplies.	30%	85%
	Waste Reduction: Target: A 30% reduction in the disposal of usable medical supplies from donor hospitals.	15%	30%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

On-Site Dental Care Foundation

Program Title	North County Oral Health and Education Program	***Recommended Amount:*** $200,000
Program Abstract & Target Population	Dentist, dental assistants, treatment case manager, and program manager provide comprehensive oral health services and education for vulnerable community members in Mountain View and Sunnyvale. Target population includes homeless, low-income seniors, LBGQT+, low-income or homeless veterans, and low-income families.	
Agency Description & Address	6525 Crown Boulevard San Jose, CA 95120 www.osdcf.org On-Site Dental Care Foundation provides comprehensive oral health services and education to those with little or no access to dental care. Services are provided via a mobile dental clinic that locates in areas identified by the public health department as experiencing health disparities. Regular practices are established in these areas, so the residents have access to on-going oral health care. On-Site's goal is to improve long term oral health as well as overall health. Services help improve patient's economic mobility, self-esteem and employability. With on-going care, patients will lose less teeth, and less functionality loss as they age. The retention rate on the Sunnyvale practice is approximately 75%, of which 90% have improved overall oral hygiene and health.	
Program Delivery Site(s)	• Columbia Community Center - 785 Morse Avenue, Sunnyvale (operated by the City of Sunnyvale)	
Services Funded By Grant	• New patient visits - exam, perio screening, oral cancer screening, blood pressure screening, full mouth xrays (45 - 60 minutes) • Patient recall visits - exam, perio screening, oral cancer screening, blood pressure screening, and prophy, and once a year 4 bitewings, and 2 periapical imaging. (60 minutes) • Prophys and SRP's (deep cleanings, cleaning under gums to remove bacteria and promote healthy gums, usually required for those who have not seen dentist in a number of years. (60 minutes) • Fillings, extractions (both surgical and simple, and includes wisdom teeth), root canals (both anterior and molar), crowns, dentures (both partials, full and stayplates) (fillings and extractions usually 60 minutes, crown preps 90 minutes, root canals 120 minutes, and dentures 60 minutes)	
Budget Summary	Full requested amount funds partial salary and benefits for dental assistants, dentist, treatment case manager, program manager and driver as well as some costs for facilities/storage, fuel, dental and office supplies, equipment maintenance, laboratory expenses and administrative overhead.	
FY2026 Funding	FY2026 Requested: $200,000	FY2026 Recommended: $200,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $200,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $200,000 FY2024 Spent: $200,000 FY2024 Annual metrics met: 99%	FY2023 Approved: $200,000 FY2023 Spent: $200,000 FY2023 Annual metrics met: 93%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	215	330
	Services provided	625	1,300
	Number of individuals reporting improved oral health after service	178	305
	Patient treatment plans completed	75%	90%
	Patients retained in care	65%	80%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Pathways Home Health and Hospice

Program Title	Pathways Un and Under-insured Care Program	***Recommended Amount:*** $60,000
Program Abstract & Target Population	Nurse, physical and occupational therapists, social worker, and program manager provide high-quality home health and hospice services to un/underinsured individuals living in the El Camino Healthcare District who are recovering from illness or surgery, managing a chronic disease, or coping with life threatening conditions so this vulnerable population receives the home health or hospice care prescribed by their doctors which allows them to remain in their homes as healthy as possible; to avoid rehospitalization and emergency room visits; and to reconnect patients back to their primary care physicians for ongoing health management.	
Agency Description & Address	585 North Mary Avenue Sunnyvale, CA 94085 www.pathwayshealth.org Pathways provides high-quality home health, hospice, and palliative care with kindness and respect, promoting comfort, independence and dignity. Non-profit, community-based Pathways has been a pioneer in home health, hospice, and palliative care since 1977. With offices in Sunnyvale, South San Francisco and Alameda, Pathways serves more than 4,000 families annually in five Bay Area counties. Pathways cares for patients wherever they live - at home, in nursing homes, hospitals and assisted living facilities. We also provide grief counseling and bereavement services free of charge to anyone in the community.	
Program Delivery Site(s)	• Both home health and hospice services are provided at the patient's residence or in an inpatient's healthcare setting such as a hospital or skilled nursing facility.	
Services Funded By Grant	As prescribed for and/or required by the specific condition for each individual patient and their diagnosis, the following types of service will be provided: • Nursing visits • Medical Social worker consultations • Physical, occupational and speech therapy visits • Home health aides for personal care • 24-hour on-call nursing services • Medication management with pharmacy oversight and consultation. • The frequency in which a patient may utilize any of these services depends on their physician orders, their individual health condition and acuity, need for skilled services, and recovery rate.	
Budget Summary	Full requested amount funds partial salaries and benefits for nurse, physical therapist, occupational therapist, social worker and program manager as well as administrative overhead.	
FY2026 Funding	FY2026 Requested: $60,000	FY2026 Recommended: $60,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $60,000 FY2025 6-month metrics met: 96%	FY2024 Approved: $60,000 FY2024 Spent: $60,000 FY2024 Annual metrics met: 83%	FY2023 Approved: $60,000 FY2023 Spent: $60,000 FY2023 Annual metrics met: 97%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	30	60
	Services provided	300	600
	Number of individuals receiving follow-up care after a health screening	30	60
	Home health patients 60-day rehospitalization rate	16%	16%
	Hospice family caregivers likely to recommend this hospice to friends and family	78%	78%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Peninsula Healthcare Connection

Program Title	New Directions	***Recommended Amount:*** $220,000
Program Abstract & Target Population	MSW/LCSW lead targeted, high-intensity community-based case management for individuals referred from El Camino Health Care Coordination facing complex medical and psychosocial needs, about half of whom are unhoused. Services are provided remotely, at homes, hospitals, board/care homes, or within the community for those experiencing homelessness.	
Agency Description & Address	1671 The Alameda, #306 San Jose, CA 95126 www.peninsulahcc.org Peninsula Healthcare Connection's (PHC) mission is to deliver integrated primary care, behavioral health care, and case management services to individuals living unhoused, those at risk of becoming unhoused, low-income and uninsured individuals, regardless of their ability to pay.	
Program Delivery Site(s)	• Remotely throughout the El Camino Healthcare District	
Services Funded By Grant	• Social Worker-to-client ratio: Not to exceed 1:25 • Program duration: 6 to 12 months, based on individual patient needs • Intensive case management to stabilize clients with imminent needs, transitioning them to less intensive community resources once stable • Flexible service delivery: Provided remotely, at homes, hospitals, SNFs, board/care homes, or within the community for those experiencing homelessness • Care coordination with inpatient and post-acute staff to engage referred patients in services • Comprehensive biopsychosocial assessment to evaluate needs and develop an individualized care plan • Crisis intervention for immediate housing, medical, mental health, and substance use needs • Assistance in accessing healthcare services, including medical, mental health, and substance use treatment, with accompaniment to appointments as needed • Collaboration with medical and behavioral health providers to support discharge planning and post-discharge care	
Budget Summary	Full requested amount funds partial salary and benefits for medical social workers, clinical supervisor, administrative specialist and some mileage and administrative overhead costs.	
FY2026 Funding	FY2026 Requested: $220,000	FY2026 Recommended: $220,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $220,000 FY2025 6-month metrics met: 91%	FY2024 Approved: $220,000 FY2024 Spent: $220,000 FY2024 Annual metrics met: 95%	FY2023 Approved: $220,000 FY2023 Spent: $220,000 FY2023 Annual metrics met: 98%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	26	52
	Services provided	500	1,000
	Number of individuals enrolled in a clinical and/or community service based on needs identified by their navigator/care manager	22	36
	"Percentage" of patients will be connected to and establish services with a minimum of one basic needs benefits program.	85%	95%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Planned Parenthood Mar Monte

Program Title	Increasing Access to Comprehensive Health Care at the PPMM Mountain View Health Center	***Recommended Amount:*** $250,000
Program Abstract & Target Population	Facilitate primary care services including Well Child and Wellness exams, immunizations, preventive screenings, episodic illness care for both children and adults, management of chronic conditions, COVID-19 testing, and reproductive health care for vulnerable patients at the agency's Mountain View Health Center. The target population are low-income, uninsured or underinsured, and reflect the region's diverse population.	
Agency Description & Address	1691 The Alameda San Jose, CA 95126 www.ppmarmonte.org Planned Parenthood Mar Monte invests in communities by providing health care and education, and by expanding rights and access for all. We are committed to providing accessible, affordable and compassionate reproductive health care, family medicine, integrated behavioral health care, and gender affirming care to the communities in which we serve. We are also committed advocates for increased access to that care.	
Program Delivery Site(s)	• Mountain View Health Center, 2500 California Street, Mountain View, CA	
Services Funded By Grant	• Wellness exams/screenings • Well Child checks (follows standard schedule) • Annual preventive visits (yearly) • Immunizations, including flu vaccines and vaccines for children and tuberculosis risk assessment and screening • Preventive screenings for disease risk (diabetes, high cholesterol, hypertension, Hepatitis C, etc.) • Episodic illness care for pediatric and adult patients (as needed) • Management of complex chronic medical conditions such as hypertension, diabetes (based on assessment and need) • Preventive screenings for cancer risk (breast, cervical, colon, testicular) • Assessments of social determinants of health • Appropriate education and counseling about healthy lifestyle choices • COVID-19 testing • All FDA-approved contraceptive methods • Gynecological exams • Pregnancy testing and counseling • Menopausal care • Diagnosis and treatment of STIs • Gender affirming care	
Budget Summary	Full requested amount funds partial salaries and benefits for center manager, site supervisor, clinicians and health services specialists as well as some facilities costs, medical/lab/pharmaceutical supplies and administrative overhead.	
FY2026 Funding	FY2026 Requested: $250,000	FY2026 Recommended: $250,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $225,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $225,000 FY2024 Spent: $225,000 FY2024 Annual metrics met: 100%	FY2023 Approved: $225,000 FY2023 Spent: $225,000 FY2023 Annual metrics met: 92%

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

Planned Parenthood Mar Monte

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	600	1,000
	Services provided	850	1,400
	Number of individuals establishing care with a PCP or specialist as a result of agency	255	510
	Hemoglobin A1c of less than 9 for diabetes patients	60%	65%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Ravenswood Family Health Network (MayView Clinics)

Program Title	Primary Healthcare, Dental and Integrated Behavioral Health Services to Low-Income Residents of El Camino Healthcare District	***Recommended Amount:*** $1,300,000
Program Abstract & Target Population	Physicians, nurse practitioner, medical assistants, scribes, dentist and dental assistant serve low-income residents of ECHD, providing high-quality, culturally competent medical, dental, and integrated behavioral health services in each patient's desired language essential to keeping district residents out of the emergency room and improving the health of the community. ECHD patients have access to pediatrics, women's health, social services, integrated behavioral health, family medicine, adult medicine, podiatry, dentistry, optometry, pharmacy, mammography, ultrasound, x-ray, lab, health education, chiropractic care, and enrollment located at the Mountain View and Sunnyvale Clinic.	
Agency Description & Address	1885 Bay Road East Palo Alto, CA 94303 https://ravenswoodfhn.org/ Ravenswood Family Health Network (RFHN) is a federally qualified health center. They operate five clinical sites—MayView Community Health Center clinics in Mountain View, Sunnyvale, and Palo Alto; and Ravenswood Family Health Center and Ravenswood Family Dentistry in East Palo Alto. They provide a comprehensive scope of health care services including pediatrics, women's health, family medicine, integrated behavioral health, social services, dentistry, podiatry, optometry, pharmacy, mammography, ultrasound, x-ray, lab, health education, chiropractic care, and enrollment. Their mission is to improve the health of the community by providing culturally sensitive, integrated primary and preventative health care to all, regardless of ability to pay or immigration status, and collaborating with community partners to address the social determinants of health.	
Program Delivery Site(s)	While most district residents come to the Mountain View and Sunnyvale clinics for their care since these sites are located within the district, ECHD residents have the option to receive services at any of the locations in Mountain View, Sunnyvale, Palo Alto, and East Palo Alto. This allows ECHD patients to access care near their home and work. • MayView Mountain View Clinic (94040) • Dental mobile clinic stationed in front of the MayView Mountain View Clinic (94040) • MayView Sunnyvale Clinic (94085) • MayView Palo Alto Clinic (94306) • Ravenswood Family Health Center in East Palo Alto (94303) • Ravenswood Family Dentistry in East Palo Alto (94303)	
Services Funded By Grant	Through this Grant, Ravenswood Family Health Network will provide services to 2,250 low-income patients residing in the ECHD service area. Services covered under the grant will include: • Routine Primary Care services and screenings • Integrated Behavioral Health Services (IBHS) • Child Well Checks • Immunizations • Chronic Disease Management for patients with diabetes and/or hypertension • Prenatal and Postpartum Care • Telehealth medical services (when clinically appropriate) • Lab services • Oral health care visits at our mobile clinic	

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery
(Including Oral Health)

Ravenswood Family Health Network

[Continued from previous page]

Budget Summary	Full requested amount funds partial salaries and benefits of physicians, nurse practitioner, medical assistants, scribes, dentist and dental assistant.		
FY2026 Funding	FY2026 Requested: $1,300,000	FY2026 Recommended: $1,300,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $1,250,000 FY2025 6-month metrics met:100%	FY2024 Approved: $1,250,000 FY2024 Spent: $1,250,000 FY2024 Annual metrics met:100%	FY2023 Approved: $1,250,000 FY2023 Spent: $1,250,000 FY2023 Annual metrics met:96%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	1,125	2,250
	Services provided	3,150	6,300
	Number of individuals establishing care with a PCP or specialist as a result of agency	435	975
	Patients ages 50-75 with appropriate breast cancer screenings.	60%	60%
	Diabetic patients with HbA1c less than 8%	55%	55%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Santa Clara Valley Healthcare, County of Santa Clara

Program Title	Dental Services in Sunnyvale and Mountain View	***Recommended Amount:*** $326,000
Program Abstract & Target Population	Dentist and dental assistants provide routine and preventative dental care services to medically underserved individuals including people at risk of homelessness and veterans in Sunnyvale and Mountain View. The population served is mostly adult Medi-Cal beneficiaries, with 38% of their target population being youth ages 0-17.	
Agency Description & Address	751 South Bascom Avenue San Jose, CA 95128 https://www.scvh.org/home Santa Clara Valley Healthcare (SCVH) is the largest public healthcare system in Northern California serving a diverse population of ~1.9 million Santa Clara County residents. SCVH is comprised of three acute care hospitals, along with a network of primary and specialty care clinics across the valley. As a public safety net institution owned and operated by the County, SCVH guarantees everyone access to care regardless of ability to pay. The majority of patients served are the most vulnerable, low-income, uninsured, and medically underserved. Patients receive primary and specialty care, behavioral health, dental services, urgent care, and a full array of inpatient services at the three hospitals, Valley Specialty Center, and fourteen Valley Health Centers supported by mobile health, dental service units, and outpatient clinics.	
Program Delivery Site(s)	• Valley Health Center Sunnyvale - 660 S Fair Oaks Ave, Sunnyvale, CA 94086 • Mountain View Dentalcare - 2486 W El Camino Real, Mountain View, CA 94040	
Services Funded By Grant	• Routine dental appointments (5 days/week) • Reminder calls to patients about dental appointments (5 days/week) • Provide dental services to 1,093 patients annually • Provide 2,734 dental encounters annually • Provide prophylactic cleaning to 25% of patients	
Budget Summary	Full requested amount funds partial salaries and benefits for dentist, dental assistants, referral coordinator and health services representative.	
FY2026 Funding	FY2026 Requested: $600,000	FY2026 Recommended: $326,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $326,000 FY2025 6-month metrics met:100%	FY2024 Approved: $355,000 FY2024 Spent: $355,000 FY2024 Annual metrics met:100%	FY2023 Approved: $440,000 FY2023 Spent: $440,000 FY2023 Annual metrics met: 93%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	546	1,093
	Services provided	1,367	2,734
	Number of individuals establishing care with a PCP or specialist as a result of agency	464	983
	Percentage of patients who receive prophylactic cleanings increase to 25% by the end of the program year	20%	25%

FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Vista Center for the Blind and Visually Impaired

Program Title	Vision Loss Rehabilitation Program	***Recommended Amount:*** DNF
Program Abstract & Target Population	Social worker, assistive technology specialists, orientation and mobility + adaptive living instructors, guidance counselor + patient care coordinators, and an optometrist provide services promoting self-sufficiency for those who are blind or visually impaired located at agency site and virtually. In FY24, 96% of all clients served were low income, 88% being very low income, and 72% extremely low-income by County guidelines. All grant funded clients in the district were low-income.	
Agency Description & Address	2500 El Camino Real, Suite 100 Palo Alto, CA 94306 www.vistacenter.org Vista Center for the Blind and Visually Impaired mission is to empower individuals who are blind or visually impaired to embrace life to the fullest through evaluation, counseling, education, and training. The purpose of the programs is to support individuals who have lost their vision by teaching essential skills to regain independence and maintain a healthy life. They provide comprehensive vision loss rehabilitation services in Santa Clara, San Mateo, Santa Cruz, and San Benito Counties. Their unique approach addresses the physical, emotional, and social needs of each client. Offering access to resources and training, individuals learn new ways to perform daily tasks and regain control of their lives and health. Vista Center continues to transform thousands of lives through innovative programs, fostering health and independence.	
Program Delivery Site(s)	Office locations: • Vista Center San Jose location - San Jose 95128 • Vista Center Palo Alto location - Palo Alto 94306 • Itinerant services such as Daily Living and Orientation & Mobility Skills are provided in the client's home and community. Our offices are fully accessible by public transport and for handicap access, and our staff are all trained to assist with vision impairment	
Services Funded By Grant	• One-hour Initial Assessments (one session) • 75-minute Low Vision Exams (one session) • One-hour Individual or Group Counseling (average 5 sessions) • One-hour Rehabilitation Classes (average 7 sessions) • One-hour Group Therapy Classes (average 7 sessions) • Each Client is served some or all the above services depending on their customized need assessment plan. A grant of $46,831 will serve 40 ECHD district residents with an average 265 service hours.	
Budget Summary	Full requested amount funds partial salaries for a social worker, an assistive technology instructor, orientation and mobility + adaptive living instructors, guidance counselor + patient care coordinators, and optometrist, and rent, utilities, mileage, supplies, and program/administrative fees.	
FY2026 Funding	FY2026 Requested: $46,831	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New in FY2026	New in FY2026	New in FY2026

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FY2026 Healthcare Access & Delivery Application Summary

Healthcare Access & Delivery (Including Oral Health)

Vista Center for the Blind and Visually Impaired

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FY2026 Dual Funding	FY2026 Requested: $81,954	FY2026 Recommended: $25,000	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $45,000 FY2025 6-month metrics met:100%	FY2024 Approved: $40,000 FY2024 Spent: $40,000 FY2024 Annual metrics met:100%	FY2023 Approved: $40,000 FY2023 Spent: $40,000 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	20	40
	Services provided	130	265
	Number of individuals receiving follow-up care after a health screening	20	40
	At least 85% of clients will report a measurable increase in confidence performing daily tasks independently, with an improvement of at least 1 point on a 5-point confidence scale, as measured by a follow-up survey within three months of service completion.	85%	85%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Acknowledge Alliance

Program Title	Resilience Consultation Program	***Recommended Amount:*** $60,000
Program Abstract & Target Population	Licensed mental health professionals (LMFT, LCSW): program director, program manager and resilience consultant provide individual and group mental health counseling to teachers, principals, other educators and school staff as well as classroom observation, professional development, and crisis intervention for educator needs contributing to the positive mental health for underserved youth. Support serves students between 2nd and 8th grade indirectly in all the schools in the Sunnyvale and Mountain View Whisman School Districts.	
Agency Description & Address	2483 Old Middlefield Way Ste. 201, Mountain View, CA 94043 www.acknowledgealliance.org At Acknowledge Alliance, the mission is to promote lifelong resilience and mental wellness in children and youth and strengthen the caring capacity of the adults who influence their lives. They envision communities where youth feel more competent and cared about in schools and in their lives; educators feel more supported and enriched in their work with students and colleagues; and education settings create safe, compassionate, and nurturing environments where everyone there feels cared for, competent and resilient. The core program is the Resilience Consultation Program which serves K-8 public and private schools in San Mateo and Santa Clara Counties and impacts over 800 educators and nearly 12,000 students (directly and indirectly) annually.	
Program Delivery Site(s)	Services at all schools in the Sunnyvale School District and Mountain View Whisman School District. • Bishop Elementary, 450 N Sunnyvale Ave, Sunnyvale • Cherry Chase Elementary, 1138 Heatherstone Way, Sunnyvale • Cumberland Elementary, 824 Cumberland Drive, Sunnyvale • Ellis Elementary, 550 E Olive Ave, Sunnyvale • Fairwood Elementary,1110 Fairwood Ave, Sunnyvale • Lakewood Elementary, 750 Lakechime Dr, Sunnyvale • San Miguel Elementary, 777 San Miguel Ave, Sunnyvale • Vargas Elementary,1054 Carson Drive, Sunnyvale • Columbia Middle School,739 Morse Ave, Sunnyvale • Sunnyvale Middle School, 1080 Mango Ave, Sunnyvale • Amy Imai Elementary, 253 Martens Ave., Mountain View • Benjamin Bubb Elementary, 525 Hans Ave. Mountain View • Crittenden Middle School, 1701 Rock St., Mountain View • Edith Landels Elementary,115 West Dana St., Mountain View • Gabriela Mistral Elementary, 505 Escuela Ave., Mountain View • Isaac Newton Graham Middle School, 1175 Castro St., Mountain View • Jose Antonio Vargas Elementary, 220 N. Whisman Rd., Mountain View • Mariano Castro Elementary, 500 Toft St., Mountain View • Monta Loma Elementary, 460 Thompson Ave., Mountain View • Stevenson Elementary, 750 San Pierre Way, Mountain View	
Services Funded By Grant	• Weekly 1:1 consulting and support to teachers and school staff (45 - 60 min sessions) • Monthly Teacher and Principal Resilience Group sessions (90 mins) • Professional development training for educators and support staff (20 - 60 min sessions) • Classroom observation and consultation (45-120 mins for observation sessions and 45 - 60 min consultation sessions)	

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Acknowledge Alliance

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Budget Summary	Full requested amount funds a portion of salary and benefits for program director, program manager and resilience consultant and some program supplies, evaluation consultant costs and administrative overhead.		
FY2026 Funding	FY2026 Requested: $80,000	FY2026 Recommended: $60,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $55,000 FY2025 6-month metrics met:100%	FY2024 Approved: $55,000 FY2024 Spent: $55,000 FY2024 Annual metrics met:99%	FY2023 Approved: $50,000 FY2023 Spent: $50,000 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	400	800
	Services provided	2,000	4,000
	Number of hours of counseling/care management sessions provided to adults	1,200	2,400
	Teachers will report an increase in positive educator/student relationships.	N/A	80%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Avenidas

Program Title	Avenidas Rose Kleiner Adult Day Health Program (ARKC)	***Recommended Amount:*** $74,200
Program Abstract & Target Population	Licensed social worker and licensed mental health contractor experienced in aging-related conditions leads case management offering daily mental health support, coordination of interdisciplinary team supports and community-based services. The program serves older adults with chronic medical conditions, cognitive impairment, mental health issues, and those at risk of social isolation at the Rose Kleiner Center in Mountain View.	
Agency Description & Address	450 Bryant Street Palo Alto, CA 94301 www.avenidas.org For over 55 years, Avenidas has been dedicated to supporting older adults and caregivers in Santa Clara County. Avenidas' mission is to empower seniors to live vibrant, engaged, and healthy lives through comprehensive programs that cater to their unique needs while providing caregivers with a dependable support system. The programs are designed to assist underserved, at-risk older adults, ensuring no one is left behind. Key programs include: • Avenidas Rose Kleiner Center, our adult day health care facility in Mountain View; • Avenidas Care Partners for personalized care management and caregiver support; • Door-to-Door transportation with volunteer drivers; • Specially curated health and wellness classes; • Avenidas Chinese Community Center to offer culturally relevant programming and services; • - Avenidas Rainbow Collective to support LGBTQ+ seniors.	
Program Delivery Site(s)	• Avenidas Rose Kleiner Center located at 270 Escuela Ave., Mountain View, CA 94040	
Services Funded By Grant	• Individual Case Management Sessions (1-hour) that include: o daily check-in with each participant to determine general well-being o daily review of progress in the Care Plan regarding psychosocial aspects o coordination of internal support services for participants as part of Interdisciplinary Team as needed o coordination with community-based service providers as needed o updating of Care Plan resulting from consultations with Team, participant, and family. • Monthly Participant Assessments by the interdisciplinary team (1-hour each) • Family Support (1-hour) Consultations with caregivers to provide caregiver guidance and strategy to keep loved ones healthy. Caregivers are surveyed for stress at initial consultation and reassessed every 6 months. • Behavioral Health Consultations (1-hour) Supporting participants with cognitive/mental health challenges	
Budget Summary	Full requested amount funds a portion of the salary for a licensed social worker and licensed mental health contracted staff.	
FY2026 Funding	FY2026 Requested: $74,200	FY2026 Recommended: $74,200

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $70,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $70,000 FY2024 Spent: $70,000 FY2024 Annual metrics met:100%	FY2023 Approved: $60,000 FY2023 Spent: $60,000 FY2023 Annual metrics met:100%

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Avenidas

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	80	115
	Services provided	2,200	3,500
	Number of hours of counseling/care management sessions provided to adults	2,200	3,500
	ARKC participants with history of ER visits do not have any emergency room visits during program year	85%	85%
	Number of caregivers who report a decrease in the caregiver stress survey by 2 points (on a scale of 4 - 20, 20 being the highest level of stress)	65%	85%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Caminar

Program Title	Domestic Violence Survivor Services Program	***Recommended Amount:*** $95,000
Program Abstract & Target Population	Clinician and others provide trauma-informed individual and family advocacy and counseling, referral assistance, safety planning, and support groups for survivors of domestic violence agency's office and Mayview Community Health Center in Mountain View. The target population served are survivors of domestic violence and intimate partner violence who live, work or attend school in the El Camino Healthcare District.	
Agency Description & Address	411 Borel Avenue, Suite 101 San Mateo, CA 94402 www.caminar.org Caminar was founded as a behavioral health care organization in San Mateo in 1964 by a group of community leaders worried about the growing mental health disparities. Today, with over 60 programs, Caminar reaches over 14,000 people across five counties; San Mateo, Santa Clara, San Francisco, Butte, and Solano. Driven by compassion, science, and evidence-based care, Caminar delivers high-quality prevention, treatment, and recovery services to those with complex mental health, substance use, and co-occurring needs.	
Program Delivery Site(s)	Service sites include Caminar's office in Palo Alto, Mayview Community Health Center, and community centers.	
Services Funded By Grant	• Individual counseling and phone contact - approximately 1 weekly call (10-60 minutes) to clients, • Groups - virtual sessions for survivors (60-90 minutes) • Accompanying clients to seek legal assistance, for clinical care and visiting family resource centers; (1-3 visits/client/year) • Contacting and building relationships with referrers (1 contact per month), • Identifying and establishing relationships with strategic program partners who serve similar populations and/or offer complementary services (1 contact per month), • Distributing program collateral in English and Spanish (1 contact per month), • Ensuring staff members knowhow to make an internal client referral (4 times per year), • Participating in meetings related to domestic violence (2 events per year) • Increasing visibility through providing community presentations as opportunities arise to groups such as the Santa Clara County Probation Department; (2-4 per year).	
Budget Summary	Full requested amount funds a portion of the salaries and benefits of the clinician, clinical program manager, facilitator and program director. Also included are some facilities and program supplies costs and administrative overhead.	
FY2026 Funding	FY2026 Requested: $131,791	FY2026 Recommended: $95,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $85,000 FY2025 6-month metrics met:100%	FY2024 Approved: $80,000 FY2024 Spent: $80,000 FY2024 Annual metrics met:100%	FY2023 Approved: $80,000 FY2023 Spent: $80,000 FY2023 Annual metrics met:98%

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Caminar

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	350	700
	Services provided	350	700
	Number of hours of counseling/care management sessions provided to adults	200	400
	Participants in supportive services (case management, advocacy, counseling, and/or support group services) who report feeling more hopeful about their futures. (Yes or No)	85%	85%
	Participants will maintain or improve their economic security. (Yes or No)	75%	75%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Caminar

Program Title	LGBTQ Speaker Bureau	***Recommended Amount:*** $78,700
Program Abstract & Target Population	Speaker bureau coordinator and drop-in center coordinator lead training and coaching for diverse multigenerational LGBTQ+ community members to share their stories with the community, students and professionals, increasing the public's understanding and support for LGBTQ+ identities and experiences in workplace and community settings. The target population is LGBTQ+ youth and adults who live, work or attend school in the El Camino Healthcare District.	
Agency Description & Address	411 Borel Avenue, Suite 101 San Mateo, CA 94402 www.caminar.org Caminar was founded as a behavioral health care organization in San Mateo in 1964 by a group of community leaders worried about the growing mental health disparities. Today, with over 60 programs, Caminar reaches over 14,000 people across five counties; San Mateo, Santa Clara, San Francisco, Butte, and Solano. Driven by compassion, science, and evidence-based care, Caminar delivers high-quality prevention, treatment, and recovery services to those with complex mental health, substance use, and co-occurring needs.	
Program Delivery Site(s)	• Various schools, community centers, nonprofit locations, and other locations throughout the El Camino Healthcare District.	
Services Funded By Grant	• The Speaker Bureau program will train LGBTQ+ youth and adults in Santa Clara County to share their stories with community members, students, and professionals, with the aim of increasing public understanding of and support for LGBTQ+ identities and experiences in workplace and community settings. Panelists will be diverse in age, ethnicity, gender, sexual orientation, religion, socioeconomic background, and ability. • Anticipated outcomes are recruiting and training panelists, completing 90 panel presentations, reaching 900+ audience members, build and sustain relationships with new District panel hosts/sites. • The goal of the Speakers Bureau is not only to raise awareness and educate the community about issues pertaining to gender and sexuality, but also to reduce stigma associated with queer identity and mental health. • To measure this goal satisfaction surveys will be completed after the presentation. • Demographics and data will be collected to ensure target audiences reached.	
Budget Summary	Full requested amount funds a portion of the salary and benefits for the speaker bureau coordinator, drop-in center coordinator, program director and some speaker stipends and administrative overhead.	
FY2026 Funding	FY2026 Requested: $157,945	FY2026 Recommended: $78,700

	FY2025	FY2024	FY2023
Funding History & Metric Performance	FY2025 Approved: $75,000 FY2025 6-month metrics met:100%	FY2024 Approved: $75,000 FY2024 Spent: $75,000 FY2024 Annual metrics met:93%	FY2023 Approved: $75,000 FY2023 Spent: $75,000 FY2023 Annual metrics met: 98%

FY2026 Dual Funding	FY2026 Requested: $157,945	FY2026 Recommended: DNF

	FY2025	FY2024	FY2023
Dual Funding History & Metric Performance	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Caminar

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	450	900
	Services provided	5	10
	Number of hours of training provided to program participants	50	100
	Hosts would recommend the panel to a friend	100%	100%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Eating Disorders Resource Center

Program Title	Support Towards Recovery and Getting Connected	***Recommended Amount:*** $25,000	
Program Abstract & Target Population	Program manager leads support groups, case management and provides resources for individuals struggling with eating disorders offered virtually, by phone and at agency site. Most individuals are low-income with half of them on Medi-Cal or uninsured.		
Agency Description & Address	2542 South Bascom Avenue Campbell, CA 95008 https://edrcsv.org The (Eating Disorders Resource Center) EDRC is a nonprofit organization dedicated to promoting recovery, creating awareness, and advocating for equitable access to treatment of eating disorders. The warmline, provides resources related to eating disorder treatment, insurance help, and general support. EDRC hosts weekly support groups for those who are struggling with eating disorders and body image, and their friends and families. EDRC assists with referrals and maintains a directory of treatment providers who specialize in eating disorders. EDRC educates healthcare providers, and community members about how to recognize eating disorders, and the treatment and resources available for someone who might be struggling. The student volunteer program introduces students to careers in mental health, and engages them in mental health advocacy through peer-to-peer education, social media campaigns, and coordinating events.		
Program Delivery Site(s)	• Services are provided at agency location, by phone and virtually.		
Services Funded By Grant	• 3 weekly support groups for those struggling as well as for family and friends • Ask the Experts series, a monthly event hosted by our support groups • Ongoing support for clients seeking treatment through the phone and email • Ongoing case management • Educational outreach programs for schools, hospitals, and community members • Guiding clients through insurance difficulties and coverage		
Budget Summary	Full requested amount funds a portion of the program manager salary.		
FY2026 Funding	FY2026 Requested: $25,000	FY2026 Recommended: $25,000	

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $25,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $25,000 FY2024 Spent: $25,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $22,500 FY2023 Spent: $22,500 FY2023 Annual metrics met:51%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	60	110
	Services provided	78	156
	Number of hours of training provided to program participants	6	12

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Friendly Voices - Phone Buddies for Seniors

Program Title	Reducing Isolation and Loneliness-Induced Depression among Seniors in the El Camino Healthcare District	***Recommended Amount:*** $14,500
Program Abstract & Target Population	Program Lead manages volunteer phone program, offering weekly calls and referrals to seniors over age 60 who live in the district, with a focus on low-income, homebound, and underserved individuals.	
Agency Description & Address	PO Box 63 Menlo Park, CA 94026-0063 www.friendlyvoices.org Friendly Voices is a five-year-old volunteer-led nonprofit that reduces social isolation for low-income and under-served seniors through safe, free, consistent weekly phone conversations with trained, compassionate volunteers. This isolation has well-documented, devastating consequences on seniors' mental and physical health (U.S. Surgeon General; WHO Committee on Social Connection). As a trusted community resource, they partner with social workers and their agencies (e.g. Community Services Agency-Mountain View, Avenidas, and Peninsula Healthcare Connections) to serve their clients. Each senior client who opts in is carefully matched 1:1 with their own screened, trained, supervised, and HIPAA compliant volunteer for steadfast, personal, phone connection and friendship lasting months to years. They are a lean, cost-effective organization. They can serve ECHD seniors at just $5/senior per week, supplemented by our additional support.	
Program Delivery Site(s)	• Phone calls are made to seniors in the ECHD service area	
Services Funded By Grant	• Individual weekly phone conversations for ECHD seniors lasting 30 minutes or more to help reduce loneliness and social isolation amongst seniors • Careful and process-based client matching 1:1 with a screened, trained, and supervised volunteer • Regular check-ins by Friendly Voices staff with referring agencies, social workers, and client families • Program management and oversight of volunteers to ensure effective and beneficial service to senior clients • Quarterly training of volunteers • Monthly mentored sessions for volunteers • Regular community outreach to senior service agencies and case managers and community partners	
Budget Summary	Full requested amount funds partial salary for program lead and community outreach contractors as well as some marketing materials and insurance costs.	
FY2026 Funding	FY2026 Requested: $14,500	FY2026 Recommended: $14,500

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $11,000 FY2025 6-month metrics met: 82%	New Program in FY2025	New Program in FY2025

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	45	55
	Services provided	800	1,700
	Number of individuals enrolled in a clinical and/or community service based on needs identified by their navigator/care manager	40	50

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Friends For Youth

Program Title	Mentoring for Mental Health	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Director of operations and program coordinator lead 1-to-1 youth mentoring program implementing social emotional learning curriculum to address challenges including adverse childhood experiences and trauma. Program includes intensive case management supports, needs assessments and referrals for services ensuring accessibility for marginalized youth with diverse linguistic and cultural backgrounds.	
Agency Description & Address	3460 West Bayshore Road Palo Alto, CA 94303 www.friendsforyouth.org Friends for Youth (FFY) is a nationally recognized, award winning direct-service agency with over four decades of measurable success in mentoring and a 100% safety rating. FFY's mission is to empower underserved youth through mentorship and community relationships, and their vision is to provide every young person who needs a mentor with a mentor. Through their 1-to-1 and site-based group mentoring programs, FFY provides quality mentoring relationships for underserved youth who need support most, with the goal of empowering them to be mentally and behaviorally healthy, emotionally secure, and equipped with social, emotional and resiliency-building skills. It is FFY's belief that through the power of mentoring, they can improve the lives of our young people who need someone in their corner.	
Program Delivery Site(s)	• Reaching out to more school districts to establish group mentoring sessions in more schools, which feeds into our 1-to-1 program if students need more intensive care.	
Services Funded By Grant	• Recruitment and intensive screening of 50+ prospective volunteer mentors • 1-to-1 mentoring sessions weekly for 52 weeks • 30 minute weekly holistic case management for each mentorship for 52 weeks • 6 bimonthly 2-hour mentorship group activities • 4 quarterly 2-hour mentor mixers and continuing education on youth mental health and development • 52 weeks of offered translation services	
Budget Summary	Full requested amount funds a portion of director of operations and program coordinator salaries.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met:72%	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met: 90%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 88%

FY2026 Dual Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	New program in FY2026	New program in FY2026	New program in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	100
	Services provided	351	702
	Number of hours of counseling/care management sessions provided to youth	351	702

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Health Connected (formerly My Digital TAT2)

Program Title	Digital Literacy & Social and Emotional Health Online	***Recommended Amount:*** $28,900
Program Abstract & Target Population	Program educators lead digital media literacy and online safety education virtual workshops for 3rd-5th grade students, teachers, staff, mental health professionals, and parents in English and Spanish in ECHD, primarily in the Mountain View Whisman School District.	
Agency Description & Address	10800 North Wolfe Road Cupertino, CA 95014 https://www.mydigitaltat2.org My Digital TAT2 is a Silicon Valley nonprofit organization addressing one of the most challenging issues facing families today: how to build the healthy habits, critical thinking, and thoughtful online behavior necessary to integrate technology into our lives in a constructive way. We do this through our youth-led programs and research-backed educational workshops that provide strategies for navigating the ever-changing digital world to schools, parents, and healthcare organizations. My Digital TAT2's focus is to help families stay connected through open communication. They emphasize early education and prevention in the students and families we work with. In the midst of increasing mental health needs for youth, they have identified an additional critical stakeholder: clinicians and mental health professionals.	
Program Delivery Site(s)	Services will be offered virtually or in person, depending on the needs of each school in the Mountain View Whisman School District. Training sessions for school counselors and mental health clinicians will be provided online. • Benjamin Bubb Elementary, Mountain View, CA 94040 • Edith Landels Elementary, Mountain View, CA 94040 • Mariano Castro Elementary, Mountain View, CA 94040 • Gabriela Mistral Elementary, Mountain View, CA 94040 • Monta Loma Elementary, Mountain View, CA 94040 • Jose Antonio Vargas Elementary, Mountain View, CA 94040	
Services Funded By Grant	• 60 and 90-minute workshops for 3rd, 4th, and 5th grade classrooms • 30-minute teacher/administrator professional development workshops • 90-minute parent/guardian education workshops in English • 90-minute parent/guardian education workshops in Spanish • 120-minute clinician and mental health professional trainee workshops for school counselors and mental health clinicians from supporting community-based organizations	
Budget Summary	Full requested amount funds partial salaries and benefits for director of curriculum & programs, teen empowerment program manager, educator training specialist, partnerships program manager, educators as well as some technology costs and administrative overhead.	
FY2026 Funding	FY2026 Requested: $28,919	FY2026 Recommended: $28,900

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $29,000 FY2025 6-month metrics met: 40%	FY2024 Approved: $29,000 FY2024 Spent: $29,000 FY2024 Annual metrics met: 61%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 63%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	350	750
	Services provided	400	850
	Number of hours of training provided to program participants	35	50

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Kara

Program Title	Bereavement Support, Grief Education & Crisis Response for the Community	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Clinical staff and program staff facilitate comprehensive bereavement support, death-related crisis response, and grief education for vulnerable populations provided via telehealth and various community locations. The target population is low-income individuals, people of color, and monolingual Spanish (or limited English) speakers, who have significant barriers to accessing grief services.	
Agency Description & Address	457 Kingsley Avenue Palo Alto, CA 94301 www.kara-grief.org Guided by the values of empathy and compassion, Kara's mission is to provide grief support for children, teens, families and adults. Serving the community for over 48 years, Kara offers comprehensive bereavement support, death-related crisis response, grief education, and therapy to children, teens, and adults in the San Francisco Bay Area and beyond. Over 200 trained and supervised volunteers with experience in healing from their own losses contribute thousands of service hours annually. Created to be accessible, Kara's peer support and crisis services are provided free of charge, in English and in Spanish, and at various locations primarily in Santa Clara and San Mateo Counties. We provide services in a hybrid model, delivering grief support, training, and crisis response via telehealth and in-person.	
Program Delivery Site(s)	• Crisis response and grief education services are provided onsite at the clients' locations or via phone or online as appropriate. • Kara Service Locations: • Main Office: 457 Kingsley Avenue, Palo Alto, CA 94301 • Youth and Family Program Site: All Saints Church, 555 Waverley Street, Palo Alto, CA 94301 • Camp Kara: Camp Arroyo, 5555 Arroyo Road, Livermore, CA 94550	
Services Funded By Grant	• Proposed Services in English and Spanish • Client intakes, typically one-hour • Individual peer support, typically weekly for one hour, unlimited duration • Group peer support in loss-specific, population specific, or general drop-in groups, biweekly for 1.5 hours (typically 8 - 10 weeks each) • Group peer support for children and teens and concurrent parent groups, (2 x per month) for 1.5 hours, unlimited duration • Annual three-day grief camp for children 6 – 17, (equivalent of 6 months of group support) • Parent support for campers, (typically 2 - 3 hours) • Specialized grief support workshops throughout the year, ranging from 2-8 hours • Individual and family consultations, typically 1 hour • Crisis response onsite services event, typically 3-6 hours • Crisis response phone consultation, typically 1 hour • Grief training and education sessions, typically 2-3 hours • Community outreach presentations, typically 1.5 - 2 hours • Grief-related psychotherapy sessions, one-hour, unlimited duration, typically weekly or biweekly	

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Kara

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Budget Summary	Full requested amount funds partial salaries for the director of adult services, assistant director of adult services, director of community outreach & crisis response, director of Spanish services, director of youth & family services.		
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met:67%	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met: 90%	FY2023 Approved: $20,000 FY2023 Spent: $20,000 FY2023 Annual metrics met: 95%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	40	85
	Services provided	150	350
	Number of hours of training provided to program participants	25	50
	90% of respondents will report Kara services provided a supportive space (“a lot" or "a great deal” from a 5-pt. scale) to support them through their grieving process.	90%	90%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Law Foundation of Silicon Valley

Program Title	Removing Barriers to Mental Health Access	***Recommended Amount:*** $70,000
Program Abstract & Target Population	Attorneys and staff lead outreach, advocacy, education, and legal services to help low-income individuals access safety-net benefits, health care, and housing to achieve better behavioral health and economic stability outcomes through medical and case management providers and at monthly legal clinics at Community Services Agency in Mountain View.	
Agency Description & Address	4 North 2nd Street, Suite 1300 San Jose, CA 95113 www.lawfoundation.org The Law Foundation of Silicon Valley addresses systemic inequities that prevent low-income individuals and communities of color in Santa Clara County from accessing legal and economic resources. Through free legal services, education, and systemic advocacy, we help vulnerable communities secure vital disability and public benefits, ensuring a greater degree of economic stability, which is shown to improve health outcomes.	
Program Delivery Site(s)	• The Law Foundation provides services at its office location in downtown San Jose, located at 4 North Second Street, Suite 1300, San Jose, CA 95113. Services are also provided to clients at other locations throughout the district when clients require home visits or other accommodation to access our services. Our team also presents to other providers within the district.	
Services Funded By Grant	This grant will allow us to dedicate the time of our attorneys and advocates to help persons living, working, or going to school in the El Camino Healthcare District residents access safety-net benefits, health care, and housing by: • Providing legal advice and ongoing representation to eligible individuals to help them access public benefits, health care, and housing. The number of individuals served can vary widely depending on the scope, complexity, and length of each case. • Providing referral(s) to another agency or a pro bono attorney when an individual's needs fall outside the scope of our expertise. • Leading outreach to eligible individuals regarding the breadth, depth, and availability of our services. • Offering monthly legal clinics at Community Services Agency (CSA) to promote outreach and accessibility to individuals eligible for services under this grant.	
Budget Summary	Full requested amount funds partial salaries and benefits for attorney, community health advocate, program management/administration, as well as facilities costs.	
FY2026 Funding	FY2026 Requested: $70,000	FY2026 Recommended: $70,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $70,000 FY2025 6-month metrics met: 84%	FY2024 Approved: $60,000 FY2024 Spent: $60,000 FY2024 Annual metrics met: 96%	FY2023 Approved: $60,000 FY2023 Spent: $60,000 FY2023 Annual metrics met: 84%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	165	275
	Services provided	179	294
	Number of hours of training provided to program participants	110	192
	Clients receiving services for benefits issues who successfully access or maintain health benefits or other safety-net benefits.	90%	90%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Lighthouse of Hope Counseling Center

Program Title	Low-Cost Counseling	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Therapists provide virtual, community-based counseling, psychological support, and education to low-income residents of ECHD. 80% of clients are people of color and all identify as low to moderate income.	
Agency Description & Address	1515 Partridge Avenue Sunnyvale, CA 94087 www.lighthouseofhopecc.org Lighthouse of Hope provides counseling, psychological support, and education to the entire community: families, parents, homeless, adolescent fathers, and high school students onsite in their schools. They support and work closely with the African-American community: 90% of the board is African-American, as is the Executive Director. Psychological health affects all parts of our lives. According to the 2025 Community Health Needs Assessment, Behavioral Health ranked high as a health need, being prioritized by more than three-quarters (77%) of the CHNA's focus groups and key informants combined. And in 2023, Santa Clara County Supervisor Susan Ellenberg said addressing the mental health and substance use crisis continues to be her top priority.	
Program Delivery Site(s)	• Services are provided virtually	
Services Funded By Grant	• Sessions are 1 hour. They may be 1-2 per week, depending on the situation. • Marriage Counseling • Family Issues: conflict resolution, divorce, relational problems • Parent Education: skills and techniques to becoming a more productive parent • Parent Counseling: provides knowledge, tools, guidance, and support to parents and guardians • Crisis Intervention: emotionally significant event or radical change in life • Violence Prevention: learn how to avoid physical and emotional scaring • Depression: sadness, loss, anger, or frustration that impacts daily living • Anxiety: feelings of fear, worry, uneasiness and dread • Mood Issues: bi-polar, pre and postpartum issues, menopause and others • Youth 12 years old plus who are exhibiting self-harm behaviors	
Budget Summary	Full requested amount funds partial salary for therapists, program assistant and executive director.	
FY2026 Funding	FY2026 Requested: $40,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $20,000 FY2024 Spent: $20,000 FY2024 Annual metrics met: 100%	New Program in FY24

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	250	500
	Services provided	2,100	4,200
	Number of adults demonstrating improvement on treatment plan goals	200	400
	Participants report their intention to follow their therapeutic plan	40%	80%
	Participants report feeling more hopeful about the future and recovery	70%	70%

El Camino Healthcare District

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Lotus Family Services

Program Title	Family Connection Program	***Recommended Amount:*** DNF
Program Abstract & Target Population	Licensed and Associate therapists/social workers will provide psychoeducational group training sessions, individual parent coaching and parent-child group retreat to identified at risk youth and their families.	
Agency Description & Address	6940 Santa Teresa Boulevard San Jose, CA 95119 https://lotusfamilies.org/ Lotus Family Services is a non-profit group behavioral health practice which implements trauma-informed, family-centric mental health services aimed at addressing the complex needs of individuals and families who have experienced trauma, Adverse Childhood Experiences and family stress. Our clients are looking to heal from family stress, trauma or separation such as divorce, experience in the foster care and adoption systems, immigration, post-incarceration reunification, or are caring for children with emotional needs which make parenting challenging (such as neurosensitivities, developmental delays and mental illness). We provide bilingual, holistic, evidence-based treatment for individuals and family systems. Our model reduces barriers and increases access to quality mental health care for traditionally underserved populations who don't have access to advanced treatment modalities.	
Program Delivery Site(s)	Services will be provided at our location, virtually, or through home-based services as appropriate. Location address: • 6940 Santa Teresa Blvd Suite 3 San Jose, CA 95119. • We will also explore partnerships with the local library and community center to host groups as an alternative site.	
Services Funded By Grant	• Four, 90 minute group psychoeducational parent training sessions • Two, 60 minute individualized parent coaching sessions per participant family • 1 full-day (8 hour) parent-child interactional retreat for all participants	
Budget Summary	Full requested amount funds partial salaries for two Clinicians and administrative support as well as office supplies, facilities/utilities and administration overhead.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	20	40
	Services provided	0	7
	Number of hours of training provided to program participants	7,560	7,560

FY2026 Behavioral Health Application Summary

Behavioral Health (Including Domestic Violence Trauma)

Maitri

Program Title	South Asian DV Services Program	***Recommended Amount:*** $50,000
Program Abstract & Target Population	Program staff facilitates transitional housing, case management, legal and immigration services, peer counseling, economic empowerment, and outreach services for South Asian and immigrant survivors of domestic violence at offered at confidential sites, virtually, or phone.	
Agency Description & Address	PO Box 697 Santa Clara, CA 95052 www.maitri.org Since 1991, Maitri has provided holistic wrap-around, confidential, free, and culturally responsive services to primarily South Asian survivors of domestic violence (DV) in the San Francisco Bay Area. Maitri addresses and mitigates their safety, emotional, housing, legal, immigration, mental health and economic security needs, while enhancing their ability to become self-sufficient. Maitri also engages in prevention activities within its community to educate, inform, and build awareness of the issues around DV with a goal to influence attitudes and social norms around gender equity and other factors that contribute to DV. Maitri's services include its Helpline, Peer Counseling, Transitional Housing (TH), Housing Stabilization, Legal Advocacy, Economic Empowerment (EEP), Mental Health support, Volunteer Engagement, Outreach, Prevention, and Policy Advocacy programs.	
Program Delivery Site(s)	• Sites are confidential to protect the safety and confidentiality of clients.	
Services Funded By Grant	Sessions can last between 30 minutes and several hours, depending on need: • Thirty-minute to four-hour legal and immigration advocacy sessions; • Thirty-minute to one-hour Peer Counseling sessions; • Economic Empowerment (EEP) workshops; • Individual housing stability sessions	
Budget Summary	Full requested amount funds partial salary and benefits for directors of survivor advocacy and organizational support, client services senior manager and legal advocate and other staff as well as occupancy, helpline/telecom and administrative overhead.	
FY2026 Funding	FY2026 Requested: $50,000	FY2026 Recommended: $50,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $50,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $50,000 FY2024 Spent: $50,000 FY2024 Annual metrics met:99%	FY2023 Approved: $50,000 FY2023 Spent: $50,000 FY2023 Annual metrics met: 99%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	20	48
	Services provided	35	70
	Number of hours of counseling/care management sessions provided to adults	35	70
	Legal clients will report increased awareness of legal rights in their situations.	70%	85%
	Crisis clients will report increased safety and wellbeing from their case management and safety planning services.	65%	75%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Momentum for Health

Program Title	La Selva Community Clinic	***Recommended Amount:*** $290,000
Program Abstract & Target Population	Provide bilingual psychiatry assessment, medication management, case management, short-term counseling, crisis counseling, and discharge planning for vulnerable clients at the La Selva Community Clinic who don't have access to treatment because they cannot afford to pay for services.	
Agency Description & Address	1922 The Alameda San Jose, CA 95126 http://www.momentuformentalhealth.org Momentum for Health is one of the largest non-profit behavioral health providers in Santa Clara County to adults who have a mental illness or substance abuse disorder. Over the last six decades, Momentum has developed a comprehensive continuum of care that includes prevention, outpatient services, day rehabilitation, residential treatment, supportive housing, and employment services to meet clients' complex needs. During fiscal year 2023-2024, Momentum served 4,752 unduplicated clients. Most clients (88%) are Medi-Cal recipients with low or no income. Among those served, 1,009 clients accessed the Crisis Stabilization Unit, with nearly all (97%) being discharged to a lower level of care. Furthermore, 95% of clients in crisis residential treatment and 70% in adult residential treatment also stepped down to a lower level of care.	
Program Delivery Site(s)	• La Selva Community Clinic, 4139 El Camino Way, Palo Alto, CA 94306 • Day Worker Center of Mountain View, 113 Escuela Ave., Mountain View, CA 94040	
Services Funded By Grant	• Psychiatry assessment, 60-90 minutes • Treatment and medication management, 30 minutes • Case management, 30-60 minutes • Short-term (individual) and crisis counseling, 45-90 minutes	
Budget Summary	Full requested amount funds partial salaries and benefits for program manager, psychiatrist, clinician and admin. Also includes some costs for program supplies and administrative overhead.	
FY2026 Funding	FY2026 Requested: $290,000	FY2026 Recommended: $290,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $290,000 FY2025 6-month metrics met: 84%	FY2024 Approved: $290,000 FY2024 Spent: $290,000 FY2024 Annual metrics met: 89%	FY2023 Approved: $290,000 FY2023 Spent: $290,000 FY2023 Annual metrics met: 75%

FY2026 Dual Funding	FY2026 Requested: $40,000	FY2026 Recommended: $40,000

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $40,000 FY2025 6-month metrics met: 96%	FY2024 Approved: $40,000 FY2024 Spent: $40,000 FY2024 Annual metrics met:100%	FY2023 Approved: $40,000 FY2023 Spent: $40,000 FY2023 Annual metrics met: 98%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	58	115
	Services provided	674	1,425
	Number of hours of counseling/care management sessions provided to adults	280	560
	Patients who report a reduction of 2 points or more in PHQ-9 measure severity of depression	75%	85%
	Patients who report a reduction of 2 points or more in GAD-7 measure severity of anxiety	75%	85%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

National Alliance on Mental Illness - Santa Clara County

Program Title	Community Peer Program	***Recommended Amount:*** $120,000
Program Abstract & Target Population	Peer mentors lead in-person, virtual, and phone support sessions for individuals with severe mental illnesses at locations set by patient and peer mentor.	
Agency Description & Address	1150 South Bascom Avenue, 24 San Jose, CA 95128 www.namisantaclara.org National Alliance on Mental Illness - Santa Clara County's (NAMI-SCC) goal is to support, educate, and provide direction for self-advocacy for those living with mental health conditions and their families. Having knowledge and finding resources provides the ability to do this. It also helps to eliminate the stigma and discrimination that still exist on many levels. NAMI-SCC is a Community Resource Center for County residents since 1975. According to the 2025 Community Health Needs Assessment, Behavioral Health ranked high as a health need, being prioritized by more than three-quarters (77%) of the CHNA's focus groups and key informants combined. And in 2023, Santa Clara County Supervisor Susan Ellenberg said addressing the mental health and substance use crisis continues to be her top priority.	
Program Delivery Site(s)	• Mentors on Unit-El Camino Hospital Behavioral Health Department 2500 Grant Road, Mountain View, CA 94040 • Various community locations: Our Mentors meet with their Participants in a common locations in Santa Clara County	
Services Funded By Grant	• Sessions are one hour; frequency varies. • Mentors on Unit work on the inpatient and outpatient units at El Camino Hospital Behavioral Health for 6 hours each week. • Mentoring for Peer Participants includes once a week one-on-one visits with a Mentor for up to four months, twice a week check-in phone calls for up to four months, an introduction to resources like Recovery Café, as well as opportunities in the community like volunteering, classes, etc. • Employment for Peer Mentors who have their own mental health condition. The wellness of these Mentors will be enhanced by the satisfaction of having paid employment and from opportunities for ongoing support and training. • Peer Connector – This entry level is intended as a support in connecting the Participant to those resources that will focus on their wellness plan, such as Recovery Café, DBSA groups, AA/NA groups, SMART Recovery, and NAMI's courses.	
Budget Summary	Full requested amount funds partial salaries for program manager, program coordinator, peer mentors, some program supplies, training costs and administrative overhead.	
FY2026 Funding	FY2026 Requested: $120,000	FY2026 Recommended: $120,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $100,000 FY2025 6-month metrics met: 82%	FY2024 Approved: $100,000 FY2024 Spent: $100,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $100,000 FY2023 Spent: $92,050 FY2023 Annual metrics met: 97%

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

National Alliance on Mental Illness - Santa Clara County

[Continued from previous page]

	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	30	60
	Services provided	1,530	3,060
	Number of hours of counseling/care management sessions provided to adults	1,530	3,060
	Participants report cooperating with their treatment plan	85%	85%
	Participants report feeling more hopeful about the future and recovery.	80%	80%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Positive Alternative Recreation Teambuilding Impact

Program Title	High Impact	***Recommended Amount:*** DNF
Program Abstract & Target Population	Two Program Coordinators, College mentors, and youth interns work with low income youth on social-emotional development and behavioral skills to empower them in developing essential life skills.	
Agency Description & Address	2576 Gumdrop Drive San Jose, CA 95148 www.partiprogram.com The Positive Alternative Recreation Teambuilding Impact (PARTI) empowers the next generation of leaders! PARTI was created in 2000 to provide activities for youth that build racial equity, gender equality, safety, and wellness. We became a 501c3 in 2007 at the urging of youth, community/ civic members, following the murder of an alumni. For 25 years, PARTI has impacted 50,000+ youth (1,000+ annually). Mission: Promote education around youth, healthy lifestyles and healthy decision making. Vision: Youth will have access to thrive regardless of race, gender, nationality, family economic status, or ability. Goal: Address academic needs, positive social connection to peers and caring adults, concern for personal and physical health, removal of barriers to employment, financial literacy, character development, civic and service, and access to education/vocation institutions.	
Program Delivery Site(s)	• We host activities at partnership schools, rent space/or in collaboration with programs at Foothill College, at community centers. libraries in cities and neighborhood where youth congregate. The purpose is to make activities, sessions, and support that are accessible.	
Services Funded By Grant	Proposed Services (July 2025 – June 2026) High Impact:(ages 12-24). Services & Frequency • 1.Life Skills Training (10-Week Curriculum) 1.5 hours per session/ 1 day a week o Motivation, goal-setting, decision-making, communication, teamwork, and leadership. o Timeline: October – December o Reach: 10 sessions in 3 cities, 20 participants per city (60 total). • 2. Pro-Social Recreation o Dance, field trips, outdoor activities, and youth-led Fusion Arts (Behavioral Health Themed). o Frequency: Monthly for 12 months, 60 participants. 4 hour per activity • 3. Self-Care & Advocacy Campaigns 2 hours per activity o Behavioral health awareness and resilience-building. o Frequency: Monthly for 12 months, 60 participants. • 4. Youth led Community Service Projects 2-4 hours per activity/ 1- day for 5 weeks development o Partnerships with Santa Clara County and Foothill/DeAnza College. o Reach: 50 participants in 3 district cities and 2 county-wide projects. • 5. Violence/Bullying Prevention o Trainings: bullying, violence, tobacco, and substance use prevention. o Reach: 10 sessions - 30 participants 1 hour	
Budget Summary	Full requested amount funds partial salaries for two program coordinators, two project coordinators, Youth Interns and Seasonal Staff as well as some facility rentals, stipends, contracted services and admin costs.	

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Positive Alternative Recreation Teambuilding Impact

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FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

	Metrics	***6-month Target***	***Annual Target***
FY2026 Proposed Metrics	Individuals served	30	60
	Services provided	30	60
	Number of hours of training provided to program participants	30	60

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Project Safety Net Inc.

Program Title	Convening Community for Youth Mental Health Promotion and Suicide Prevention in North Santa Clara County	***Recommended Amount:*** DNF
Program Abstract & Target Population	The Convening Community for Youth Mental Health Promotion and Suicide Prevention program convenes community members, organizations, and public agencies in the areas of youth mental health, well-being, and suicide prevention to build relationships and share information about resources. This grant would fund outreach and community meetings in Mountain View, Los Altos and Sunnyvale.	
Agency Description & Address	4000 Middlefield Road, Building t5 Palo Alto, CA 94303 www.psnyouth.org Project Safety Net (PSN) is a coalition of community-based organizations and community members dedicated to youth mental health and suicide prevention in northern Santa Clara County and southern San Mateo County. PSN's mission is to mobilize community support and resources for youth suicide prevention and mental wellness. PSN is a coalition working on community education, outreach, and training; access to quality youth mental health services; and policy advocacy. PSN's vision is that young people are empowered, in partnership with the whole community, to advocate for themselves and their peers. Youth suicide is ended. Stigma is non-existent, and high-quality mental health services are culturally relevant, accessible, and well-utilized. PSN envisions a community where youth and young adults feel safe, supported, and accepted.	
Program Delivery Site(s)	• PSN has provided services at City of Mountain View's and City of Sunnyvale's facilities. MOUs will be executed once sites best suited for the community meetings are determined during the outreach phase.	
Services Funded By Grant	• Three 2-hour community meetings over the course of 12 months • Facilitation of community meetings by PSN's Director of Community Partnerships • Opportunities for young people to develop, implement, and evaluate community meetings. Approximately 2 hours each per activity: planning, conducting outreach, attending the meeting, and evaluating.	
Budget Summary	Full requested amount funds partial salary for Director of Community Partnerships (0.25 FTE) as well as non-personnel expenses related to three (3), 2-hr community convening meetings.	
FY2026 Funding	FY2026 Requested: $44,451	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026 **ECHD funded different program from PSN in FY2023*

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	20	60
	Services provided	20	180
	Number of hours of training provided to program participants	40	120
	Participants report a 20% increase in identifying youth mental health and suicide prevention resources in their community as assessed by pre/post- survey.	25%	75%
	Participants report a 20% increase in making appropriate referrals to services as assessed by pre/post- survey.	25%	75%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Red-White and Blue Charity

Program Title	(IEOP) Individual Empowerment Opportunity Program	***Recommended Amount:*** DNF
Program Abstract & Target Population	Social Worker and Case Manager will provide case management and therapy as well as facilitate a primary care visit for low income individuals and families that are homeless or in temporary shelters.	
Agency Description & Address	1800 South Grant Street San Mateo, CA 94402 www.redwhiteandbluecharity.org Red-White and Blue Charity, 501(c)(3) non-profit human services organization, is dedicated to assisting individuals and families experiencing homelessness. To date, the agency has supported over 3,500 individuals through a comprehensive range of services, including housing, medical care, mental health therapy, employment assistance, and life skills training. These services aim to foster community growth and promote improvements in public transportation infrastructure, enhancing accessibility for the populations they serve. The organization operates within an organization design framework that includes non-profit structure 501(c)(3), policies and a clear financial plan. Red-White and Blue Charity, 501(c)(3) non-profit human services organization, is dedicated to assisting individuals and families experiencing homelessness and reincarnations.	
Program Delivery Site(s)	• We aim to have the services provided at our office located in Campbell and San Mateo, Ca. Services are provided in the shelter and people living outdoors. We take the services to them that live outdoors or transitional housing.	
Services Funded By Grant	• Target Population: We are targeting the disabled and homeless who are currently living in temporary shelters. In addition, we are targeting those individuals, children, families, and seniors who are currently living alone, on a low fixed income, or unemployed or underemployed. We have developed numerous relationships with transitional housing programs, emergency housing units, and other partners who are housing Santa Clara County's neediest individuals. Specific outcomes and objectives: Our procedures for working with individuals consist of a Continuum of Care that focuses on a comprehensive intake system (to assess areas of mental and physical needs), the creation of a Personal Development Plan (PDP), follow-up systems, and Client Review (CR) to determine that individuals are making progress, connecting with community resources, and improving their overall personal and physical health. We meet (60 minutes)1x week for case management, 1x week for therapy, and 1x a month for primary care.	
Budget Summary	Full requested amount funds partial salaries Associated Clinical Social Worker, Administrator, Web Developer, LCSW Director and Case Manager as well as facilities/utilities, food, consultants, insurance and workmen compensation costs.	
FY2026 Funding	FY2026 Requested: $167,700	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Red-White and Blue Charity

[Continued from previous page]

	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	750	1,500
	Services provided	750	1,500
	Number of individuals enrolled in a clinical and/or community service based on needs identified by their navigator/care manager	750	1,600
	Participants complete a depression on our PHQ-9 healthcare Questionnaire during a 60-minute assessment session or in addition Participants can completing a WHO-5 is a self-report instrument measuring mental well-being during a 60-minute therapy session.	50%	100%
	Clients who attend at least a 30-minute weekly treatment planning and objectives assessed by therapist and care management pre/post survey therapist at end of session	50%	100%

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Sunnyvale Neighbors of Arbor Including LaLinda (SNAIL)

Program Title	Our target audience for this grant is school aged children in the El Camino Health and El Camino Healthcare District and more specifically in the North Sunnyvale area, in which SNAIL is located.	***Recommended Amount:*** DNF
Program Abstract & Target Population	LMFT will provide evidence-based health and wellness services that address emotional and mental well being for low-income youth.	
Agency Description & Address	PO BOX 62072 Sunnyvale, CA 94089 SNAIL - Sunnyvale Neighbors of Arbor Including LaLinda The organization is a nonprofit benefit organization and is not for the private gain of any person. S.N.A.I.L. supports the following goals: • To promote community involvement and participation. • To establish and maintain an adequate line of communication between the City of Sunnyvale and the residents of the community. • To provide a community voice to city staff, school personnel, and the community at large concerning the implementation of services, community needs, and events. • To recruit volunteers and sponsors to aid in the service to the community. • To generate, through fundraising activities, revenue for the purpose of enhancing the quality of life in the area.	
Program Delivery Site(s)	• Virtual platforms/ through zoom and also at Bishop elementary school and Columbia Middle school.	
Services Funded By Grant	• Individual Assessments – One-time comprehensive evaluation to identify client needs. • Individual Therapy Sessions – 50-minute sessions, provided weekly for 8-10 sessions per individual. • Group Counseling Sessions – 90-minute sessions, conducted biweekly to support emotional well-being, peer connection, anxiety and depression. • Educational Presentation – One-hour session, delivered quarterly, covering mental health awareness and coping strategies. • Social Skills & Engagement Program – Monthly one-hour sessions focusing on communication, teamwork, and emotional regulation. • Psychoeducation on Abuse Prevention & Recovery – One-hour session, conducted quarterly, providing education and support for trauma recovery.	
Budget Summary	Full requested amount funds partial salary for LMFT and administrative staff as well as some admin and program delivery supply costs.	
FY2026 Funding	FY2026 Requested: $10,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	25	50
	Services provided	3	6
	Number of hours of counseling/care management sessions provided to youth	10	20

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

Youth Community Service (YCS)

Program Title	Service-Learning for Youth Wellness & Community Connections	***Recommended Amount:*** DNF
Program Abstract & Target Population	Youth Community Service staff will seek to enhance low-income youth awareness of community issues while promoting behavioral and mental health development through a two part program at Mountain View Los Altos High School.	
Agency Description & Address	P.O. Box 61000 Palo Alto, CA 94306 http://www.youthcommunityservice.org Youth Community Service (YCS) was founded in 1990 as a unique community education partnership among the counties of Santa Clara and San Mateo including cities such as Mountain View and Los Altos to bridge our communities through youth service. Our mission is to elevate youth voice and agency to raise community connection, equity, and resilience through service. YCS engages our youth in developing real-life skills, empathy for the needs of others, social justice awareness, and a sense of connectedness, purpose, and efficacy. YCS utilizes a community decision-making model that amplifies the voices of youth to create our programs. In the academic year of 2023-24 we engaged over 14,000 participants who collectively contributed over 90,000 hours of community service.	
Program Delivery Site(s)	• Mountain View High School, 3535 Truman Ave, Mountain View, CA 94040	
Services Funded By Grant	• Part 1) 6-8 Week AVID Service-Learning Curriculum at Mountain View High School: o AVID In-class service-learning lessons (6 weeks) o Student capstone presentation consultations (1 week) o Collaborating meetings and communication with students and community agencies (ongoing) o Reflection and evaluation (1 week) o Service Day field trip (1 day) • Part 2) Spring Enrichment and Leadership Program for MVLA High School District o Service-learning curriculum (1 week) o Smaller group collaboration o Student advocacy capstone project consultations o Collaborating sessions with students and community agencies o Reflection and evaluation	
Budget Summary	Full requested amount funds partial salaries for Program Manager and two Program Coordinators as well as transportation costs.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	60
	Services provided	600	660
	Number of hours of training provided to program participants	1,350	1,800

FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

YWCA Golden Gate Silicon Valley

Program Title	ARISE	***Recommended Amount:*** $105,000
Program Abstract & Target Population	Marriage and family therapists, licensed clinical social workers, and clinical trainees lead trauma-informed counseling services for low-income and LGBTQ+ clients healing from domestic violence and sexual assault offered in English and Spanish via telehealth and in person.	
Agency Description & Address	375 South Third Street San Jose, CA 95112 https://yourywca.org YWCA Golden Gate Silicon Valley (YWCA GGSV) powers its mission with programs focused on the following: Empowering people and communities in healing from the trauma of racism, bigotry, and violence. Achieving solutions to homelessness for people impacted by racism, gender inequality, and violence. Inspiring opportunity and economic security by closing the prosperity and education gap. Services are provided to those impacted by race and gender inequality and use an intersectional approach that recognizes the compounding impact of oppression. YWCA GGSV offers healing, empowerment, and prevention programs to survivors of domestic violence, sexual assault, and human trafficking, and their families. They offer housing continuum options, like homelessness prevention, emergency shelter, rapid rehousing, supportive housing, and affordable housing. They also provide licensed childcare and employability programs.	
Program Delivery Site(s)	• Telehealth services in the YWCA Emergency Shelter (confidential location) • Telehealth in emergency housing, survivor's homes, or other convenient, safe spaces • In-person therapy at YWCA located at 375 South 3rd Street, San Jose, CA 95112 • In-person therapy at YWCA located at 451 Lytton Avenue, Palo Alto, CA 94301 • Telehealth group counseling	
Services Funded By Grant	• Individuals receive either 1 or 2 hours of therapy per week • 1-1.5 hours of community group counseling sessions per week: ongoing groups include LGBTQIA+ Support Group for Queer & Trans Survivors of Sexual Assault and Domestic Violence, Support Group for Survivors of Domestic Violence • Four 1-hour survivor workshops: topics may include Understanding Trauma Responses, the Importance of Self-Care and Mindfulness, etc. • 1.5-hours of therapy group counseling sessions per week: each group runs 8 weeks, topics include Dialectical Behavioral Therapy Skills, Mindfulness Stress-based Reduction • Two 1-hour parent/guardian workshops: How to support a survivor and yourself after a traumatic event	
Budget Summary	Full requested amount funds partial salaries and benefits for bilingual staff clinician, associate director of clinical services, administrative coordinator, staff clinician and LGBTQIA+ program coordinator, as well as some facilities and supplies costs and administrative overhead.	
FY2026 Funding	FY2026 Requested: $105,000	FY2026 Recommended: $105,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $90,000 FY2025 6-month metrics met: 93%	FY2024 Approved: $90,000 FY2024 Spent: $90,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $85,000 FY2023 Spent: $85,000 FY2023 Annual metrics met: 93%

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FY2026 Behavioral Health Application Summary

Behavioral Health
(Including Domestic Violence Trauma)

YWCA Golden Gate Silicon Valley

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	15	32
	Services provided	150	320
	Number of hours of counseling/care management sessions provided to adults	150	320
	Individuals who receive 3 or more counseling sessions increase their knowledge of trauma and the effects of trauma on their lives	80%	85%
	Individuals who receive 3 or more counseling sessions experience a reduction of trauma symptoms.	75%	80%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

AbilityPath

Program Title	Pathways to Health & Wellness - Adult Day Program	***Recommended Amount:*** DNF
Program Abstract & Target Population	AbilityPath's Adult Day Program serves adult individuals with intellectual or developmental disabilities. This grant would fund the Pathways to Health and Wellness curriculum promoting healthy living routines and practices through nutrition & fitness education and activities focused on building an individuals overall physical and emotional well-being. Programming is focused on wellness classes, fitness/exercise classes, and education & learning.	
Agency Description & Address	350 Twin Dolphin Drive, Suite 123 Redwood City, CA 94065 http://www.abilitypath.org AbilityPath empowers people with special needs to achieve their full potential through innovative, inclusive programs, and community partnerships. Their vision is a world where people of all abilities are fully accepted, respected, and included. Founded in1920, AbilityPath's services have expanded through the years to meet the evolving needs and interests of individuals with developmental disabilities and their families. With educational, therapeutic, vocational, and family support services, they are distinctive in providing support to individuals throughout their lifetime. They are continually building on past successes and best practices to offer more services in inclusive environments.	
Program Delivery Site(s)	• 3864 Middlefield Road, Palo Alto, CA 94043 • 2248 North First Street, San Jose, CA 95131	
Services Funded By Grant	• 3 one-hour group wellness classes will be offered each week • 3-5 group fitness/exercise classes will be offered each week • 6 hours of classroom-based and community-based learning, 5 days/week	
Budget Summary	Full requested amount funds partial salaries for Regional Director (0.03FTE), Director of Recreation Therapy (0.02FTE), and Day Program Coordinator (0.24FTE) and Supervisor (0.24FTE), as well as non personnel items like transportation, vehicle costs, and supplies.	
FY2026 Funding	FY2026 Requested: $22,124	FY2026 Recommended: DNF

Funding History & Metric Performance

FY2025	FY2024	FY2023
New for FY2026	New for FY2026	New for FY2026

FY2026 Proposed Metrics

Metrics	***6-month Target***	***Annual Target***
Individuals served	2	4
Services provided	432	1,296
Number of individuals who report 150 minutes or more of physical activity per week	2	4
75% of participants will engage in recreation and physical fitness activities at least three times per week, improving their ability to be more active in all aspects of life, maintain or achieve a healthy weight, and reduce chronic disease risk.	37%	75%
Fitness Education and Health & Wellness classes are 45-minute classes offered 5x a week and 65% of participants will rarely or never require support to make healthy food choices to avoid diet-related chronic health conditions.	33%	65%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

American Diabetes Association

Program Title	Project Power	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Participant supplies, program incentives and program manager time providing diabetes prevention program for youth ages 5-12 at school and community partner sites within the El Camino Healthcare District.	
Agency Description & Address	2451 Crystal Drive, Suite 900 Arlington, VA 22202 www.diabetes.org American Diabetes Association's (ADA) mission is to prevent and cure diabetes and to improve the lives of all people affected by diabetes. The ADA is the authoritative voice in the diabetes community, providing research, information and public awareness, and advocacy. For 85 years, ADA has been working on the frontlines and within multiple areas to educate at-risk populations, protect the rights of people with diabetes in their daily lives, and pioneer clinical and research breakthroughs by fostering a pipeline of the best and brightest scientists and by educating healthcare professionals on standards of care in diabetes.	
Program Delivery Site(s)	• El Camino YMCA 2400 Grant Road, Mountain View, CA 94040 • Northwest YMCA 20803 Alves Drive, Cupertino, CA 95014 • School sites within the ECHD TBD	
Services Funded By Grant	• Project Power offers one hour group settings by trained counselors which focuses on nutrition, physical activity, and healthy lifestyles to combat childhood obesity, type 2 diabetes, heart disease and stroke. • The curriculum includes interactive nutrition workshops, physical activities and games, family engagement, cooking demonstrations and SMART goal setting. • Project Power in Santa Clara works within out-of-school or after care programs throughout the year. The program offers six one-hour lessons over three weeks. • Both programs utilize interactive sessions for youth and families, our end goal is to improve and maintain increased physical activity levels in youth, empower children to adapt healthy lifestyle habits and to encourage and develop sustainable healthy lifestyles within the household. • Project Power, utilizing the Catch Kids Club (CKC) curriculum, is composed of nutrition education and physical education/activities to foster active living and healthy eating.	
Budget Summary	Full requested amount funds primarily participant incentives and partner stipends, and it also goes to partial salaries for program manager, executive director and other fees and administrative overhead costs.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met: 98%	New program in FY24

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	80	160
	Services provided	360	720
	Number of individuals who report 150 minutes or more of physical activity per week	24	48

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Bay Area Women's Sports Initiative

Program Title	BAWSI Girls at Bishop Elementary School	***Recommended Amount:*** $39,000
Program Abstract & Target Population	Coach led afterschool fitness activities promoting physical activity and self-esteem in 2nd through 5th grade girls at Bishop Elementary School in Sunnyvale. Target population are from under-resourced households attending Bishop. 51% of students at Bishop Elementary School are socioeconomically disadvantaged, 44% are English learners, and 66% of students are Hispanic/Latino.	
Agency Description & Address	2635 North First Street, Suite 149 San Jose, CA 95134 https://bawsi.org Founded in 2005 by sports executive Marlene Bjornsrud and soccer stars Julie Foudy and Brandi Chastain, BAWSI's mission is to mobilize the women's sports community to engage, inspire and empower girls in under-resourced neighborhoods and children with disabilities. Their free programs level the playing field so that ALL children and youth have access to play. They have enrolled over 26,000 children in San Mateo and Santa Clara counties; and, engaged over 9,500 volunteers. Over the past 20 years, BAWSI has worked in partnership with community to get girls from under-resourced neighborhoods and children with disabilities off the sidelines and into the game. By providing free programming on-site at schools, BAWSI removes some of the most common community-identified barriers to participation in sports.	
Program Delivery Site(s)	Bishop Elementary School: 450 N Sunnyvale Avenue, Sunnyvale, CA 94085	
Services Funded By Grant	BAWSI Girls will offer a total of at least 35 group sessions at Bishop Elementary School as detailed below: • Two in-school assemblies for all 2nd through 5th grade girls • Eight 75-minute after-school sessions in the Fall 2025 season (for up to 65 girls) led by two Athlete Leaders and a group of student-athlete volunteers. We typically have a 10:1 BAWSI Girls to coach ratio at these sessions. • Eight 75-minute after-school sessions in the Spring 2026 season (for up to 65 girls) • Eight 15-minute sessions in the Fall season and 8 sessions in the Spring season for 5th Grade Coaches to develop leadership skills and to execute a day of running the entire site • One 4-hour BAWSI Game Day event during the 2025-2026 school year where BAWSI Girls attend a women's sporting event at a college campus, hosted by student-athlete volunteers	
Budget Summary	Full requested amount funds partial salaries for two BAWSI coaches, BAWSI programs and business management staff, partial staff benefits, and partial costs for: supplies, storage, mileage, program materials, BAWSI Game Day field trip, and administration.	
FY2026 Funding	FY2026 Requested: $84,716	FY2026 Recommended: $39,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $39,000 FY2025 6-month metrics met: 100%	FY2024 Approved: $26,000 FY2024 Spent: $26,000 FY2024 Annual metrics met: 95%	FY2023 Approved: $26,000 FY2023 Spent: $26,000 FY2023 Annual metrics met:93%

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Bay Area Women's Sports Initiative

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FY2026 Dual Funding	FY2026 Requested: $84,716	FY2026 Recommended: $20,000	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $20,000 FY2025 6-month metrics met: 95%	FY2024 Approved: $15,000 FY2024 Spent: $15,000 FY2024 Annual metrics met:100%	FY2023 Approved: $15,000 FY2023 Spent: $15,000 FY2023 Annual metrics met:86%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	55
	Services provided	530	1,160
	Number of individuals who report 150 minutes or more of physical activity per week	50	55
	Average weekly attendance percentage	80%	80%
	Percentage of participants who respond positively (4's and 5's) to the statement, "I like to exercise."	60%	60%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Bay Area Women's Sports Initiative

Program Title	BAWSI Rollers at Ellis Elementary School	***Recommended Amount:*** $21,000
Program Abstract & Target Population	Coach led adaptive physical activities for special education students in kindergarten through 5th grade at Ellis Elementary School in Sunnyvale. 29% of students at Ellis Elementary are socioeconomically disadvantaged, 40% are English learners, and 7.8% are students with disabilities. The same report indicates that 37% of students at Ellis are Asian and 38% are Hispanic/Latino, demonstrating that three-quarters of the school's student body are ethnic minorities	
Agency Description & Address	2635 North First Street, Suite 149 San Jose, CA 95134 https://bawsi.org Founded in 2005 by sports executive Marlene Bjornsrud and soccer stars Julie Foudy and Brandi Chastain, BAWSI's mission is to mobilize the women's sports community to engage, inspire and empower girls in under-resourced neighborhoods and children with disabilities. Their free programs level the playing field so that ALL children and youth have access to play. They have enrolled over 26,000 children in San Mateo and Santa Clara counties; and, engaged over 9,500 volunteers. Over the past 20 years, BAWSI has worked in partnership with community to get girls from under-resourced neighborhoods and children with disabilities off the sidelines and into the game. By providing free programming on-site at schools, BAWSI removes some of the most common community-identified barriers to participation in sports.	
Program Delivery Site(s)	Ellis Elementary School: 550 East Olive Ave, Sunnyvale, CA 9408	
Services Funded By Grant	• 8 in-school one-hour sessions during the Fall 2024 season • 8 in-school one-hour sessions during the Spring 2025 season	
Budget Summary	Full requested amount funds partial staff time for BAWSI coaches and school support staff, administration and insurance costs, and program supplies.	
FY2026 Funding	FY2026 Requested: $66,000	FY2026 Recommended: $21,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $21,000 FY2025 6-month metrics met:100%	FY2024 Approved: $21,000 FY2024 Spent: $21,000 FY2024 Annual metrics met:100%	FY2023 Approved: $21,000 FY2023 Spent: $21,000 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	15	15
	Services provided	120	240
	Number of individuals who report 150 minutes or more of physical activity per week	15	15
	Average weekly attendance	80%	80%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Chinese Health Initiative (CHI)

Program Title	Chinese Health Initiative	***Recommended Amount:*** $275,000
Program Abstract & Target Population	Manager, administrative coordinator, and outreach contractors provide culturally and linguistically competent hypertension, diabetes, and cardiovascular disease screening events and education programs at senior centers, community centers, and virtually to the Chinese community.	
Agency Description & Address	2500 Grant Road Mountain View, CA 94040 https://www.elcaminohealth.org/services/chinese-health-initiative CHI promotes awareness of health disparities and prevention of health conditions that commonly affect the Chinese population by providing culturally and linguistically competent outreach and education. Offerings include screenings and workshops on diabetes, hypertension, and emotional health. CHI also provides access to health information from physicians and other credible sources, and programs that address physical health and emotional well-being. CHI's curriculum is evidenced-based and culturally adapted to the unique health needs of the Chinese population. Key areas of focus: • Health disparities: diabetes, hypertension, emotional health • Comprehensive lifestyle programs for physical and emotional health • Access to care and resources	
Program Delivery Site(s)	Chinese Health Initiative 2500 Grant Rd, Mountain View CA 94040	
Services Funded By Grant	• Educational workshops on diabetes. • Ask-a-Dietitian webinars. How to make healthy diet choices, monthly. • Ask-a-Doctor webinars. Topics including diabetes, health prevention • Diabetes Prevention Series (DPS). 4-month program, Diet, Exercise, Sleep, Stress-Management, 3x/year • Monthly support group for participants who completed DPS to support efforts in maintaining a healthy lifestyle, led by registered dietitian. • Pre-Diabetes Screening. Finger prick A1c tests for DPS participants. • Emotional well-being: Emotional resiliency helps individuals manage health more effectively. • Monthly culturally tailored educational resources • Monthly workshops by mental health professionals. Topics include mental health services, anxiety, anger-management and more. • Bilingual Resource Hub • Bilingual Digital Guide • Physician Network. 122+ Chinese-speaking physicians help lower barriers to culturally competent care. • Health Resource Guide for Seniors. Bilingual. Helps seniors navigate healthcare system and access resources. • Free/low-cost clinics, resources. distributed to vulnerable populations and those without health insurance. • eNewsletters. Bilingual. Health-related articles.	
Budget Summary	Full requested amount funds partial salaries for a manager, two coordinators, and program operational costs.	

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Chinese Health Initiative (CHI)

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FY2026 Funding	FY2026 Requested: $290,000	FY2026 Recommended: $275,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $275,000 FY2025 6-month metrics met: 92%	FY2024 Approved: $275,000 FY2024 Spent: $268,972 FY2024 Annual metrics met: 97%	FY2023 Approved: $267,000 FY2023 Spent: $267,000 FY2023 Annual metrics met: 94%
FY2026 Dual Funding	FY2026 Requested: $35,000	FY2026 Recommended: $30,000	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met:100%	FY2024 Approved: $20,000 FY2024 Spent: $20,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $20,000 FY2023 Spent: $20,000 FY2023 Annual metrics met:99%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	760	1,520
	Services provided	1,700	3,600
	Number of individuals with one or more improved biometrics (e.g., BMI, weight, and/or A1c)	50	150
	Participants who are very likely (9-10 rating) to recommend CHI to a friend or colleague	85%	85%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

City of Sunnyvale - Columbia Neighborhood Center

Program Title	ShapeUp Sunnyvale, Year 6	***Recommended Amount:*** $57,200
Program Abstract & Target Population	Grant assistant, recreation staff and therapeutic program staff facilitate inclusive fitness sessions and nutrition education programs for low-income Sunnyvale residents of all ages at the Columbia Neighborhood Center, Sunnyvale Community Center and Columbia Middle School in Sunnyvale.	
Agency Description & Address	785 Morse Avenue Sunnyvale, CA 94085 www.sunnyvale.ca.gov Columbia Neighborhood Center (CNC) supports and empowers youth and families so that the children of the community will develop the life skills necessary to be successful in school and beyond. The Centers' priorities are to serve: a) at-risk, limited income Sunnyvale youth as defined by their ability to qualify for Free and Reduced-Price School meals and/or the City's Recreation Scholarship Program, and b) families in Sunnyvale with limited access to basic services. CNC is a partnership between the Sunnyvale Elementary School District, the City of Sunnyvale, non-profit and business organizations. A priority area for CNC's program and service development is residents' physical health and wellness. In Fiscal Year 2023/24, CNC recorded a total of 42,879 participant hours in all programs, services and activities.	
Program Delivery Site(s)	• Columbia Neighborhood Center, 785 Morse Ave., Sunnyvale • Sunnyvale Community Center, 550 E. Remington Drive, Sunnyvale • Columbia Middle School, 739 Morse Ave., Sunnyvale	
Services Funded By Grant	• Two sessions (8-weeks each, 1x/week) of healthy meal kits with all necessary ingredients and instructions • Two seasons (Winter, Spring or Summer) of fitness activity selected by each participant (usually 8 weeks in length, 2x per week) • Weekly drop-in basketball and fitness room for Columbia Middle School students during Late Start Day (1x/week for 90 minutes x 36 weeks) • In-person cooking classes, 2x per session for up to 10 healthier cooking participants for a total of 4 cooking classes • Specific outreach to serve up to 3 individuals with disabilities in each session of fitness which will require additional staffing, to provide a one-to-one aide in each fitness class (1x/week x 8 weeks) for a total of 6 individuals with disabilities.	
Budget Summary	Full requested amount funds partial salary and benefits for grant assistant, recreation staff, therapeutic program staff and also incentives for participants, costs for caterer, cooking classes, fitness activities fees and administrative overhead.	
FY2026 Funding	FY2026 Requested: $57,200	FY2026 Recommended: $57,200

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $49,000 FY2025 6-month metrics met:100%	FY2024 Approved: $44,000 FY2024 Spent: $44,000 FY2024 Annual metrics met: 98%	FY2023 Approved: $45,000 FY2023 Spent: $45,000 FY2023 Annual metrics met: 86%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	50	130
	Services provided	490	1,410
	Number of individuals who report consuming at least 3 servings of fruits and vegetables per day	80	88
	Participants who report at least a 30-minute weekly increase in moderate to strenuous physical activity as assessed by pre/post survey.	70%	80%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Fresh Approach

Program Title	Culturally Responsive Nutrition Education & Produce Prescriptions at Food Pantries	***Recommended Amount:*** $50,000
Program Abstract & Target Population	Nutrition educators provide culturally relevant nutrition education and cooking workshops, farmers market voucher program, and resources for low-income community members at Columbia Neighborhood Center in Sunnyvale and food pantries. The target population is individuals and families of all ages in households not meeting self-sufficiency standards and living in neighborhoods where access to affordable, nourishing produce is a key need in addressing health disparities.	
Agency Description & Address	5060 Commercial Circle, Suite C, Concord, CA 94520 www.freshapproach.org Guided by an emphasis on community engagement—and in collaboration with a wide range of values-aligned partners—Fresh Approach is building more resilient food and farming systems through healthy food access, nutrition education, and urban agriculture. Fresh Approach's three-pronged strategy includes (1) providing food sourced with dignity that reflects cultural preferences for those in urgent need, and expanding choices via financial incentives at traditional and mobile farmers' markets, as well as through farm-fresh food boxes (2) offering nutrition education via the VeggieRx program, which "prescribes" the fruit and vegetable vouchers, and, (3) increasing community participation in climate resilience initiatives by providing resources and education on gardening, composting, and water management. Dignity, choice, and cultural competence are essential pillars that guide all the programmatic design and implementation.	
Program Delivery Site(s)	• Columbia Neighborhood Center - 785 Morse Avenue Sunnyvale, CA 94088-3707 • Second Harvest of Silicon Valley - additional sites for cooking demonstrations to be identified as a part of this project.	
Services Funded By Grant	• VeggieRx Nutrition & Cooking Workshops – Four 16-week series (eight 1.5 hour classes each), taught online for accessibility. • Online Peer Support Sessions – Two follow-up sessions per series (1 hour/each) • VeggieRx Vouchers – $30 per household per week for 16-week duration, redeemable at farmers' markets. • In-Person Cooking Demonstrations at Food Pantries – Held once per month for six-nine months of the grant term. • Cooking Demo Vouchers – $4 per participant per session to purchase fruits and vegetables at farmers' markets. • Trauma-Informed, Culturally Responsive Curriculum – Classes integrate best practices in Language Justice and Trauma-Informed Care.	
Budget Summary	Full requested amount funds partial salaries and benefits for program manager, program specialist, marketing & communications manager, community ambassador, as well as some costs for outreach materials, program supplies, farmers' market stipends and VeggieRx vouchers and administrative overhead.	
FY2026 Funding	FY2026 Requested: $75,000	FY2026 Recommended: $50,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $40,000 FY2025 6-month metrics met: 40%	FY2024 Approved: $74,000 FY2024 Spent: $74,000 FY2024 Annual metrics met: 83%	FY2023 Approved: $73,500 FY2023 Spent: $73,500 FY2023 Annual metrics met: 53%

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FY2026 Diabetes & Obesity Application Summary

Fresh Approach

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	203	406
	Services provided	505	1,010
	Number of individuals who report consuming at least 3 servings of fruits and vegetables per day	63	126
	Participants who report at least a 1-point increase on a 1-5 scale that "I have enough education and peer support that provides me knowledge and resources to improve my health and prevent some disease"	65%	70%
	Participants who report increased knowledge of and confidence in using nutrition incentive programs at farmers' markets (including Calfresh/SNAP, WIC) as assessed by pre/post surveys after classes series	70%	85%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Living Classroom

Program Title	Expanding Our Reach to Mountain View's 7th graders ***Recommended Amount:*** $67,000
Program Abstract & Target Population	Program staff and instructors lead garden-based Farm to Lunch healthy eating curriculum through growing healthy produce in school edible gardens for transitional kindergarten through 7th grade students in the Mountain View Whisman School District.
Agency Description & Address	183 Hillview Avenue Los Altos, CA 94022 www.living-classroom.org Living Classroom teaches State Standards–aligned and California Nutrition Standards-aligned, garden-based, experiential outdoor lessons at local schools and through our Farm to Lunch program. Their mission is to make education come alive by bringing nature to the classroom and to empower the next generation of children to become healthy eaters, environmental champions and inquisitive learners. They do this by creating edible and native gardens at each school served and holding lessons outdoors in those gardens that engage students through growing, harvesting and preparing fresh vegetables and fruits from school gardens and hands-on learning about science, social studies, and math. Living Classroom provides essential nutrition and environmental education within the Mountain View Whisman School District which directly benefits the community's children and their families.
Program Delivery Site(s)	• Benjamin Bubb Elementary School, 525 Hans Avenue, Mountain View, CA 94040 • Edith Landels Elementary School, 115 West Dana Street, Mountain View, CA 94041 • Amy Imai Elementary School, 253 Martens Avenue, Mountain View, CA 94040 • Gabriela Mistral Elementary School, 505 Escuela Avenue, Mountain View, CA 94041 • Jose Antonio Vargas Elementary School, 220 N. Whisman Avenue, Mountain View, CA 94043 • Mariano Castro Elementary School, 505 Escuela Avenue, Mountain View, CA 94041 • Monta Loma Elementary School, 460 Thompson Avenue, Mountain View, CA 94043 • Stevenson Elementary School, 750-B San Pierre Way, Mountain View, CA 94043 • Theuerkauf Elementary School, 1625 San Luis Avenue, Mountain View, CA 94043 • Crittenden Middle School, 1701 Rock Street, Mountain View, CA 94043 • Graham Middle School, 1175 Castro Street, Mountain View, CA 94040
Services Funded By Grant	• Provide 700 one-hour Next Generation Science Standards-aligned school-day lessons to T/K-7th grade and SAI students . The ECHD grant will fund approximately 32% (224) of our lessons including instructor and gardener staff, all lesson and garden supplies, and a small portion of our administrative staff and expenses. • Continue Farm to Lunch food tastings partnering with the Child Nutrition Services during lunchtime tastings. Goal is at least one tasting at eleven schools (based on availability of produce and Food Truck), reaching an average of 150 students per taste-testing per school site. • Maintain 22 edible and native habitat gardens for LC school day lessons, where students grow vegetables, and Farm to Lunch program produce. • Survey students after nutritionally focused lessons to document changes in healthy eating behavior. • Roll out 7th grade Meso America social studies lesson to all 7th graders featuring a healthy snack station and an edible garden planting/harvesting station
Budget Summary	Full requested amount funds partial salary and benefits for program manager, instructors, garden manager, executive director and business manager as well as some mileage costs, program supplies, misc. costs and administrative overhead.

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Living Classroom

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FY2026 Funding	FY2026 Requested: $67,000	FY2026 Recommended: $67,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $60,000 FY2025 6-month metrics met: 80%	FY2024 Approved: $60,000 FY2024 Spent: $60,000 FY2024 Annual metrics met: 86%	FY2023 Approved: $60,000 FY2023 Spent: $60,000 FY2023 Annual metrics met: 99%
FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	3,400	4,000
	Services provided	6,000	12,500
	Number of individuals who report consuming at least 3 servings of fruits and vegetables per day	750	1,900
	Percentage of students reporting increased knowledge of healthy habits (healthy eating, healthy living, and/or experiences)	70%	80%
	Percentage of teachers surveyed rating Living Classroom lessons a "4" or above (on a 5-point scale)	90%	95%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Playworks, Northern California

Program Title	Playworks, Sunnyvale and Mountain View	***Recommended Amount:*** $228,800
Program Abstract & Target Population	Program coordinators, site specialists, and a site coordinator lead physical activity and positive school climate program at 8 Sunnyvale School District elementary schools for grades K-5, with an average free or reduced lunch program rate of 32% and 80% who identify as students of color. Expanding programming to include 2 under-resourced elementary schools for grades K-5 in the Mountain View Whisman School District - 90% of students identify as people of color, have an average Free and Reduced Lunch (FRL) rate of 66%, and more than half are English language learners.	
Agency Description & Address	638 3rd Street Oakland, CA 94607 https://www.playworks.org/northern-california/ Playworks is the leading organization to use play as a way to give children foundational skills for healthy bodies and social/emotional development – on the playground, in the classroom, and in the community. Their evidence-based early intervention programs enhance physical activity levels and foster the development of crucial social-emotional and 21st century skills while improving school culture. Playworks helps schools and districts make the most of recess through on-site staffing, consultative support, professional development, free resources, and more. With the vision that one day every child in America will have access to safe, fun, healthy play every day, their mission is to improve the health and well-being of children by increasing opportunities for physical activity and safe, meaningful play.	
Program Delivery Site(s)	All schools where services will be delivered are located in the Sunnyvale Elementary School District and Mountain View Whisman School District: • Bishop Elementary, 450 N. Sunnyvale Ave., Sunnyvale, CA • Cherry Chase Elementary- 1138 Heatherstone Way, Sunnyvale, CA • Cumberland Elementary-824 Cumberland Dr., Sunnyvale, CA • Ellis Elementary-550 E. Olive Ave., Sunnyvale, CA • Fairwood Explorer-1110 Fairwood Ave., Sunnyvale, CA • Lakewood Tech EQ Elementary- 750 Lakechime Dr., Sunnyvale, CA • San Miguel Elementary - 777 San Miguel Ave., Sunnyvale, CA • Vargas Elementary – 1054 Carson Dr., Sunnyvale, CA • Mariano Castro Elementary–500 Toft St, Mountain View, CA 94041 • Gabriela Mistral Elementary– 505 Escuela Ave, Mountain View, CA 94041	

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Playworks, Northern California

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Services Funded By Grant	Playworks will provide the following services to 8 Sunnyvale and 2 Mountain View schools: • Recess Facilitation- Playworks staff create a respectful, fun playground, ensuring all kids are included in recess and physical activity for up to 30-45 minutes every school day. • Junior Coach Leadership Program- Playworks staff coordinate with teachers to recruit students from the upper grades to serve as Junior Coaches, supporting a peer-led recess. These youth leaders participate in trainings weekly (Coach), bi-weekly (Relay, or monthly (Team-up) on leadership, group management, conflict resolution techniques, and strategies effective in preventing bullying behaviors. • Class Game Time-Playworks staff lead individual classes a minimum of once monthly for 30–45 minute periods, offering individualized support on conflict resolution strategies and rules of games, with the goals of inclusivity, teamwork, and cooperation. • Staff Orientation- To strengthen school partnership, Playworks offers 45 minute professional development trainings a minimum of one time each year to all staff.	
Budget Summary	Full requested amount funds partial salaries for 3 program coordinators, 2 site specialists, and 1 site coordinator		
FY2026 Funding	FY2026 Requested: $228,819	FY2026 Recommended: $228,800	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $200,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $200,000 FY2024 Spent: $200,000 FY2024 Annual metrics met:100%	FY2023 Approved: $200,000 FY2023 Spent: $200,000 FY2023 Annual metrics met:100%
FY2026 Dual Funding	FY2026 Requested: $42,299	FY2026 Recommended: $40,000	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $40,000 FY2025 6-month metrics met:100%	FY2024 Approved: $40,000 FY2024 Spent: $40,000 FY2024 Annual metrics met: 99%	FY2023 Approved: $40,000 FY2023 Spent: $40,000 FY2023 Annual metrics met:98%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	4,800	4,800
	Services provided	9,600	9,600
	Number of individuals who report 150 minutes or more of physical activity per week	4,800	4,800
	Percent of educators who report that students receive 30 minutes or more of physical activity at recess every day (150 minutes a week)	N/A	95%
	% of educators report that Playworks helps the school create supportive learning environments	N/A	94%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Roots Community Health

Program Title	Improving Diabetes and Obesity Health Outcomes for African American Community	***Recommended Amount:*** $70,000
Program Abstract & Target Population	Clinical staff provide diabetes and obesity screening, education, and awareness activities to the African American community and other people of color in Sunnyvale and Mountain View.	
Agency Description & Address	7272 MacArthur Boulevard Oakland, CA 94605 www.rootsclinic.org Roots was founded in 2008 to address the overwhelming health needs of historically neglected African American/Black communities. Their mission is to uplift those impacted by systemic inequities and poverty. They accomplish this by combating health disparities, delivering quality primary and behavioral healthcare, and integrating social and navigation services, workforce development, housing resources, and policy advocacy. Through its integrated approach to Whole Health, Roots' programs address the nuanced needs of the communities we serve. Their services are designed to meet individuals 'where they are,' centering member voice and cultural congruence through street-, place-, and community-based provision across multiple locations. Roots serves over 10,000 people annually across Alameda and Santa Clara counties. Roots' South Bay patient population represents roughly one-third of the organization's entire member-base.	
Program Delivery Site(s)	Roots South Bay Headquarters: 1811 S 7th St, Suite C, D & E, San Jose, CA 95112	
Services Funded By Grant	• Participate in three large community events to creatively provide awareness and promote diabetes and obesity prevention. • Partner with at least one place of worship and/or community center to provide 7 smaller education and diabetes testing events • Provide a1c testing for ~100 adults at the aforementioned community events. • Facilitate monthly (12 total) opportunities for individuals/families to participate in obesity reduction through virtual and live interventions including group wellness, health education sessions, exercise classes, and cooking demonstrations. • Follow up with 10 individuals with diabetes or prediabetes and provide outreach and linkage to a primary care provider and diabetes management groups. • Post on all Roots social media platforms a campaign that promotes diabetes prevention and healthy nutrition.	
Budget Summary	Full requested amount funds partial salaries for a Clinical Program Specialist, Clinical Programs Manager, RN, Program Director, and Communications Manager, agency benefits, as well as office and glucose testing equipment, incentives, administrative overhead, and other operating costs.	
FY2026 Funding	FY2026 Requested: $89,194	FY2026 Recommended: $70,000

	FY2025	FY2024	FY2023
Funding History & Metric Performance	FY2025 Approved: $35,000 FY2025 6-month metrics met: 78% *Funded in ECH	FY2024 Approved: $35,000 FY2024 Spent: $35,000 FY2024 Annual metrics met: 100% *Funded in ECH	New Program in FY2024

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FY2026 Diabetes & Obesity Application Summary

Roots Community Health

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	65	130
	Services provided	90	180
	Number of individuals who report consuming at least 3 servings of fruits and vegetables per day	15	30
	At least 70% of participants will demonstrate a 10% improvement in diabetes and nutrition knowledge, as measured by pre/post surveys.	55%	70%
	At least 60% of participants with diabetes or prediabetes will report adopting at least one new self-management behavior (e.g., dietary change, increased physical activity) after six months, measured by self-reported surveys.	45%	60%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

Silicon Valley Bicycle Coalition

Program Title	Bike to Health	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Program funds group bike rides promoting physical activity and education for youth and adults in communities with health disparities. Rides originate from transit-friendly, accessible locations, and the program improves physical and mental health through a combination of monthly bike rides as well as providing peer bike champions for new rider education.	
Agency Description & Address	PO Box 1927 San Jose, CA 95109 www.bikesiliconvalley.org Silicon Valley Bicycle Coalition (SVBC) was incorporated as a 501(c)(3) in 1993 to create a community that values, includes, and encourages bicycling for all purposes for all people in Santa Clara and San Mateo Counties. SVBC builds healthier and more just communities by making bicycling safe and accessible for everyone. SVBC works with public agencies, non-profit organizations, business partners, and community members to reach the overarching goal of increasing the number and diversity of people using bicycles for everyday transportation. The intention behind this is to address many of our society's most pressing problems, particularly human health, as well as mental/emotional health, social isolation, and civic engagement.	
Program Delivery Site(s)	• Mountain View Transit Center - 650 W Evelyn Ave. Mountain View, CA 94041 • Plaza del Sol, Sunnyvale - 200 W Evelyn Ave, Sunnyvale, CA 94086 • Eagle Park - 650 Franklin St, Mountain View, CA 94041 • Cuesta Park - 615 Cuesta Dr, Mountain View, CA 94040 • De Anza Park - 1150 Lime Dr, Sunnyvale, CA 94087 • Start locations of group rides need to be transit-friendly and near restrooms, water, and a table for refreshments and paperwork. Program location can also be determined pending community partner interest.	
Services Funded By Grant	8 events of 2-4 hours in duration. Activities and services include: • Bike safety check • Helmet fit • Education about safe, predictable riding • Supportive environment to practice biking for active transportation and improved health outcomes	
Budget Summary	Full requested amount funds partial staff salaries for Deputy Director and Program Manager, as well as non-personnel items to support group rides and admin / benefits.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $20,000 FY2025 6-month metrics met:100%	FY2024 Approved: $20,000 FY2024 Spent: $20,000 FY2024 Annual metrics met:74%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	90	240
	Services provided	100	300
	Number of individuals who report 150 minutes or more of physical activity per week	45	120
	Participants who report a minimum of 150 minutes of weekly physical activity as assessed by pre/post survey	75%	75%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

South Asian Heart Center

Program Title	AIM to Prevent	***Recommended Amount:*** $310,000
Program Abstract & Target Population	Full requested amount funds partial staff time for the executive director, health educator, health coach coordinator, administrative/participant relations coordinator, and program supplies.	
Agency Description & Address	2490 Hospital Drive, Suite 302 Mountain View, CA 94040 www.southasianheartcenter.org The South Asian Heart Center, a non-profit since 2006, aims to reduce the incidence of diabetes and heart attacks in Indians and South Asians through culturally tailored, evidence-based screening, education, and health coaching prevention services. This group faces higher, earlier, and more severe disease despite lacking the traditional risk factors. The AIM to Prevent™ program offers risk assessments, lifestyle counseling, and health coaching to thousands. STOP-D™, a CDC Full Plus recognized program, prevents and halts diabetes progression with targeted lifestyle and behavioral interventions.	
Program Delivery Site(s)	They deliver services directly to their participant clients from their Mountain View and Los Gatos offices, through video consultations, online workshops, and coaching sessions. • Mountain View: 2490 Hospital Drive Suite #302, Mountain View, CA 94040 • Los Gatos: 777 Knowles Avenue, Los Gatos, CA 95032	

Services Funded By Grant	• Seminars
	• Health Fairs/Awareness campaigns: 90-240min, 2-3/month
	• Community Huddles: 90min, 10/year
	• 4 MEDS workshops (Meditation, Exercise, Diet, and Sleep): 90min, 1/month/workshop
	• Intermittent and Conscious Eating workshop: 75min, 2-3/year
	• AIM to Prevent Program Encounters:
	  o Onboarding: 20min, 1/participant
	  o Biometrics: 10min, 4/participant
	  o Risk Assessment: 40min, 2/participant
	  o Results Review: 40min, 1/participant
	  o Coaching: 40min, 8-10/participant
	  o Yearly Checkups: 40min, 1/participant
	• STOP-D/WellMET Program Encounters:
	  o All encounters of the AIM to Prevent program, plus
	  o CDC workshops, 22 modules repeated 4-6 times/year
	  o Motivational Newsletters: 50 articles, 4-6 times/year
	• SLIMFIT Program Encounters:
	  o Dietary Counseling: 60min, 6/participant
	• Continuous Glucose Monitoring Program Encounters:
	  o Coaching: 20min, 2-3/participant
	  o Workshops: 30min, 3 modules/participant
	• Individual Consultation Encounters:
	  o Dietary Counseling: 60min, 1-2/participant
	  o Nutrition Coaching: 30min, 1/participant
	  o Lifestyle Medicine Consultation: 60min, 1-2/participant
	  o Clinical Consults: 30min, 1/participant
	  o Laboratory Report: 30min, 1/participant
	  o Calcium Scoring Report: 30min, 1/participant
	• Physician Education: 60min 1-2 sessions/year
	• eNewsletters: 8-10/subscriber/year	

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

South Asian Heart Center

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Budget Summary	Full requested amount funds partial staff time for the executive director, health educator, health coach coordinator, administrative/participant relations coordinator, and program supplies.		
FY2026 Funding	FY2026 Requested: $330,000	FY2026 Recommended: $310,000	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $310,000 FY2025 6-month metrics met: 96%	FY2024 Approved: $310,000 FY2024 Spent: $310,000 FY2024 Annual metrics met:94%	FY2023 Approved: $ FY2023 Spent: $ FY2023 Annual metrics met: 100%
FY2026 Dual Funding	FY2026 Requested: $70,000	FY2026 Recommended: $60,000	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $60,000 FY2025 6-month metrics met:97%	FY2024 Approved: $50,000 FY2024 Spent: $50,000 FY2024 Annual metrics met: 94%	FY2023 Approved: $50,000 FY2023 Spent: $50,000 FY2023 Annual metrics met: 100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	260	530
	Services provided	1,160	2,350
	Number of individuals who report 150 minutes or more of physical activity per week	65	135
	Average percent change in levels of self-reported physical activity assessed at baseline and subsequent follow-up.	10%	10%
	Average percent change in levels of self-reported vegetable consumption assessed at baseline and subsequent follow-up.	20%	20%

FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

YMCA of Silicon Valley

Program Title	YMCA Summer Camp	***Recommended Amount:*** $82,600
Program Abstract & Target Population	Camp leaders provide support to bridge the opportunity gap during the summer through quality enrichment activities, free healthy meals/snacks, daily physical exercise, nutrition education, socio-emotional support, safe spaces for youth, and providing financial assistance to ensure access for low-income families at the El Camino YMCA and Northwest YMCAs, two branches of the YMCA of Silicon Valley serving Mountain View, Sunnyvale, Los Altos and Cupertino, and will be located at five school sites: Stevens Creek, Almond, Graham, West Valley and Oak elementary/middle Schools.	
Agency Description & Address	550 South Winchester Boulevard, Suite 250 San Jose, CA 95128 www.ymcasv.org As one of the largest nonprofits in Silicon Valley, YMCA of Silicon Valley serves more than 167,000 individuals annually from communities that span from Gilroy to Redwood City. Locations include 10 YMCA health and wellness branch facilities and YMCA Camp Campbell, a wilderness resident camp in the Santa Cruz Mountains. In addition, YMCA has a presence in more than 300 schools and partner agencies throughout the region, providing childcare, after school programs, summer camps, food distribution, health and fitness activities, and initiatives to engage adults with youth for positive experiences. The Y serves people of all backgrounds, ages, capabilities, and income levels, providing program subsidy and financial assistance to those in need.	
Program Delivery Site(s)	• Stevens Creek Elementary School, Cupertino Union School District, 10300 Ainsworth Dr, Cupertino, CA 95014 • Almond Elementary School, Los Altos School District, 550 Almond Ave., Los Altos CA 94022 • Graham Middle School, Mountain View Whisman School District, 1175 Castro St., Mountain View, CA 94040 • West Valley Elementary, Cupertino Union School District, 1635 Belleville Way., Sunnyvale, CA 94087 • Oak Elementary, Los Altos School District, 1501 Oak Ave., Los Altos, CA 94024	
Services Funded By Grant	• Each participant engages in a minimum of 60 minutes of moderate to vigorous activity daily • Healthy Lifestyle and Nutrition Education activities and lessons provided weekly • At least 1 serving of fresh fruits/vegetables provided to each participant, daily • Financial assistance provided for all qualified families for up to 9 weeks. • The Y provides care from 8:00 am to 5:00 pm, M-F. The regular camp program starts at 9am and concludes at 4pm. Extended care is provided before and after camp at no additional cost to families. • Each of the following components is built into every one of our camps: Physical Activity and Fitness; Healthy Meals/Snacks; Healthy Lifestyle and Nutrition Education; Caring Adult Role Models; Social and Emotional Learning (SEL) and Literacy Skills/Reading for Pleasure.	
Budget Summary	Full requested amount funds partial salaries for camp leaders.	
FY2026 Funding	FY2026 Requested: $82,620	FY2026 Recommended: $82,600

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FY2026 Diabetes & Obesity Application Summary

Diabetes & Obesity

YMCA of Silicon Valley

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Funding History & Metric Performance	FY2025	FY2024	FY2023	
	FY2025 Approved: $80,000 FY2025 6-month metrics met:100%	FY2024 Approved: $80,000 FY2024 Spent: $80,000 FY2024 Annual metrics met:100%	FY2023 Approved: $67,000 FY2023 Spent: $67,000 FY2023 Annual metrics met:100%	
FY2026 Proposed Metrics	***Metrics***		***6-month Target***	***Annual Target***
	Individuals served		270	500
	Services provided		6,400	13,400
	Number of individuals who report 150 minutes or more of physical activity per week		216	400
	Individuals who report their child increased physical activity by 30 minutes/week as compared to physical activity level prior to attending YMCA Summer Camp		90%	90%

FY2026 Chronic Conditions Application Summary

Chronic Conditions (Other than Diabetes & Obesity)

American Heart Association

Program Title	Healthy Hearts Initiative	***Recommended Amount:*** $119,200
Program Abstract & Target Population	The AHA Healthy Hearts Initiative program builds capacity for community organizations to incorporate evidence-based blood pressure screening and referral systems. The program uses a "train the trainer" model whereby the AHA trains staff at partner organizations to serve as "community health workers." Service areas targeted for this grant are predominantly in Mountain View and Sunnyvale.	
Agency Description & Address	1111 Broadway, Suite 1360 Oakland, CA 94607 https://www.heart.org/en/affiliates/california/greater-bay-area/ With a mission to be a relentless force for a world of longer, healthier lives, the American Heart Association (AHA) is one of the largest and most trusted voluntary health organizations in the world. With donor support, the AHA funds life-saving research, while translating science into clinical guidelines, public health policy, and community initiatives. Their 2030 impact goal is to equitably increase healthy life expectancy and advance cardiovascular health for all, including identifying and removing barriers to health care access and quality. To achieve this goal nationally, the AHA has been transitioning our community health work from serving individuals to creating systems changes. By building capacity for community partners to implement the AHA's evidence-based systems, the AHA can reach people where they are and exponentially expand our impact.	
Program Delivery Site(s)	Committed Program Delivery Sites (MOUs included in application): • MidPen Housing: o Monte Vista Terrace, 1101 Grant Road, Mountain View, CA 94040 o Fair Oaks Plaza, 690 South Fair Oaks Avenue, Sunnyvale, California 94086 o Paulson Park, 111 Montebello Ave, Mountain View, California 94043 o Homestead Park, Moulton Plaza, 1601 Tenaka Pl. Sunnyvale, CA 94087 o The Fountains, 2005 San Ramon Drive, Mountain View, California 94043 • Fresh Approach- Events at sites including: o El Camino Health, 2500 Grant Rd, Mountain View 94040 o Sunnyvale Community Services, 1160 Kern Ave, Sunnyvale 94085 • Avenidas- Screenings at senior facilities including: o Avenidas Rose Kleiner Center, 270 Escuela Ave, Mountain View, CA 94040 o Mountain View Senior Center, 266 Escuela Ave, Mountain View, CA 94040	
Services Funded By Grant	The AHA will provide the following services with each community partner: • Lead an initial partnership meeting to co-determine blood pressure systems change plans and timelines to integrate screening and referral into operations. • Hold at least monthly meetings with project leads to provide training and resources, and to collaborate on project management. • Support the acquisition of supplies or equipment, such as validated blood pressure cuffs, ongoing as relevant throughout the project. • Share AHA science, expertise and technical assistance as identified as a need by partners and their constituencies as relevant throughout the project. • Provide implementation support to ensure sustainable systems changes at the organizational level.	
Budget Summary	Full requested amount funds partial (0.70 FTE) Community Impact Manager salary and benefits, plus subawards for community partners to implement screening and referral systems, and some administrative overhead and indirect costs.	

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FY2026 Chronic Conditions Application Summary

Chronic Conditions
(Other than Diabetes & Obesity)

American Heart Association

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FY2026 Funding	FY2026 Requested: $119,249		FY2026 Recommended: $119,200	
Funding History & Metric Performance	FY2025	FY2024	FY2023	
	FY2025 Approved: $100,000 FY2025 6-month metrics met:99%	FY2024 Approved: $100,000 FY2024 Spent: $100,000 FY2024 Annual metrics met: 100%	FY2023 Approved: $100,000 FY2023 Spent: $100,000 FY2023 Annual metrics met: 95%	
FY2026 Proposed Metrics	***Metrics***		***6-month Target***	***Annual Target***
	Individuals served		7,508	30,025
	Services provided		7,540	30,200
	Number of individuals completing one or more health screenings		7,500	30,000
	Percentage of individuals who screen positive for elevated blood pressure and therefore receive hypertension resources and referral to healthcare providers as needed		25%	25%

FY2026 Chronic Conditions Application Summary

Chronic Conditions
(Other than Diabetes & Obesity)

Breathe California of the Bay Area, Golden Gate and Central Coast

Program Title	Seniors Breathe Easy	***Recommended Amount:*** $28,800
Program Abstract & Target Population	Health educator & Community Outreach Specialist provide workshops, screenings, and trainings for older adults with respiratory conditions and their caregivers located at community locations, seniors' homes, senior centers, and virtually across ECHD service area.	
Agency Description & Address	1469 Park Avenue San Jose, CA 95126 https://lungsrus.org/ Breathe California of the Bay Area, Golden Gate, and Central Coast is a 114-year-old community-based, voluntary 501(c) 3 non-profit that is committed to achieving clean air and healthy lungs. Their Mission: As the local Clean Air and Healthy Lungs Leader, Breathe California fights lung disease in all its forms and works with its communities to promote lung health. Goals: tobacco-free communities, healthy air quality, reduced lung diseases. They serve over 40,000 individuals per year with programs in health education, health policy and research, focusing on populations with health disparities. COVID, COPD, and RSV, respiratory diseases that affect seniors most seriously, and the greater recognition of the importance of building health equity, make Seniors Breathe Easy vital to the health of the ECHD community of seniors.	
Program Delivery Site(s)	Breathe California will continue to provide services to multiple locations throughout the ECHD. We currently have a formal partnership with the City of Mountain View Senior Center, which serves over 300 individuals each day. They are located at 266 Escuela Avenue in Mountain View. The City of Santa Clara senior center is another formal partner (1303 Fremont Street, Santa Clara), along with the India Center (21251 Stevens Creek Blvd, Cupertino), Life's Garden (450 Old San Francisco Road, Sunnyvale), and the Santa Clara County Library District (13 S. San Antonio Road, Los Altos). • Cupertino Senior Center • Belmont Village in Sunnyvale • City of Santa Clara Senior Center • India Center in Cupertino • Mid-Pen Resident Services locations in Mountain View and Sunnyvale • Life's Garden in Sunnyvale • Hillview Community Center • The Silicon Valley Council of the Blind in Mountain View • Cedar Crest Rehab Center • Mountain View Buddhist Temple • Santa Clara County Library District	

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FY2026 Chronic Conditions Application Summary

Breathe California of the Bay Area, Golden Gate and Central Coast

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Services Funded By Grant	• Health education presentations on a variety of health and wellness topics • Health screenings for lung health (spirometry), blood pressure (sphygmomanometer), and oxygen saturation (oximetry) • Breathing exercise instruction for increased energy and feelings of wellness • In-home assessments for respiratory and falling hazards (1-2 hours) using EPA respiratory checklist and Stanford falls checklist • Tobacco cessation assistance by telephone, in person consultation, or group sessions (1-3 hours) • Educational materials on many senior health issues, especially respiratory health and air quality needs • Public Information Media Campaign to encourage COVID, influenza, pneumonia, and RSV vaccinations in this high-risk population • Information and referral on additional senior topics • Caregiver education
Budget Summary	Full requested amount funds partial salaries for health educator, director of programs, communications director, and community outreach specialist, and agency benefits and program support costs.
FY2026 Funding	FY2026 Requested: $28,800 FY2026 Recommended: $28,800

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $28,000 FY2025 6-month metrics met:100%	FY2024 Approved: $28,000 FY2024 Spent: $28,000 FY2024 Annual metrics met:94%	FY2023 Approved: $25,000 FY2023 Spent: $25,000 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	150	350
	Services provided	400	1,100
	Number of individuals completing one or more health screenings	50	125
	Education: 50% of participants will indicate a gain in knowledge through Pre/Post presentation surveys or raise of hand which is collected after health education presentations.	50%	50%

FY2026 Chronic Conditions Application Summary

Chronic Conditions
(Other than Diabetes & Obesity)

Stanford Health Care - Trauma Injury Prevention Program Administration

Program Title	Walk Towards Wellness: One Step at a Time	***Recommended Amount:*** DNF
Program Abstract & Target Population	Occupational Therapist and Injury Prevention/Project Coordinator will work with eligible low-income seniors to educate them on exercise, nutrition and creating safe walking routes within their community.	
Agency Description & Address	300 Pasteur Drive Stanford, CA 94305 www.stanfordhealthcare.org Serving over 2.6 million people, Stanford Medicine is the only Level 1 Adult and Level 1 Pediatric Trauma Center verified by the American College of Surgeons (ASC) on the peninsula of the San Francisco Bay Area. We provide specialized care to over 3,200 patients per year and handle 20-25 consults daily. The mission of Stanford Medicine is to care, educate, and discover. The Injury Prevention Program is an important part of this Level 1 Trauma Center. The program looks at local data on mechanism of injury and finds interventions to address those injury areas. Stanford Medicine offers home-based and community-based programs to address these significant problems.	
Program Delivery Site(s)	• Columbia Neighborhood Center, 785 Morse Avenue, Sunnyvale, CA 94088-3707 • We currently have memorandum of understandings with the cities of Mountain View and Cupertino and will amend agreements if proposal is accepted.	
Services Funded By Grant	• Participant telephone health screening and baseline evaluation of Life Space Mobility will be administered. Estimated target of 48 calls at 30 minutes each and enrollment of 8-12 participants. • Participants who do not fit the criteria for the program or decline to participate will be offered health related resources in the community. • Multi-component, 2-hour, six-session series that includes various health education topics ranging from injury prevention, nutrition, exercises to creating safe walking routes, connecting older adults with others and the built environment • One final (2-hour) in-person session to review goal achievement and maintenance plan. • Fifteen-minute follow-up call at after 6-12 months to assess progress in maintaining goal and maintenance plan. • Program design, recruitment and evaluation by Injury Prevention Project Program Coordinator and Occupational Therapist dedicated to the program.	
Budget Summary	Full requested amount funds partial salary for Occupational Therapist and Injury Prevention/Project Coordinator as well as funds for snacks, water bottles, materials & participant gift cards.	
FY2026 Funding	FY2026 Requested: $27,667	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Chronic Conditions Application Summary

Stanford Health Care - Trauma Injury Prevention Program Administration

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	12	36
	Services provided	72	216
	Number of individuals completing one or more health screenings	12	36
	Participants who report at least 150 minutes per week of walking as recommended by the physical activity guidelines as assessed by pre/post survey.	40%	80%
	Participants who report not experiencing a fall within the lasts 90 days	40%	80%

FY2026 Economic Stability Application Summary

Day Worker Center of Mountain View

Program Title	Healthy Meals Program	***Recommended Amount:*** $35,000
Program Abstract & Target Population	Kitchen workers and the purchase of vegetables, fruit, and healthy proteins sources to provide healthy meals for day workers and their families located at the agency site in Mountain View.	
Agency Description & Address	113 Escuela Avenue Mountain View, CA 94040 https://www.dayworkercentermv.org The Day Worker Center of Mountain View is a non-profit organization that connects the day worker community with employers in a safe and reliable environment in addition to offering various programs for workers and community members such as providing healthy meals, ESL classes, technology classes, workshops about worker's rights and much more. The Day Worker Center's vision is a world of diverse communities where day laborers live with full rights and responsibilities in an environment of mutual respect, peace and harmony.	
Program Delivery Site(s)	• Day Worker Center of Mountain View, 113 Escuela Ave., Mountain View, CA 94040	
Services Funded By Grant/How Funds Will Be Spent	• Average of 98 healthy meals each week • Daily healthy protein, whole grains, fresh fruits and vegetables • Two cooks working 38 hours per week each • Workers eat together, fostering camaraderie and kinship among them • Relevant Zoom classes and workshops are provided when possible	
Budget Summary	Full requested amount funds partial kitchen workers and the purchase of healthy protein sources, vegetables and fruit.	
FY2026 Funding	FY2026 Requested: $35,000	FY2026 Recommended: $35,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $35,000 FY2025 6-month metrics met:100%	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met:100%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met:100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	205	370
	Services provided	2,750	5,500
	Number of individuals connected to a sustainable source of healthy food (CalFresh/SNAP, food banks, etc.)	205	370
	9% of participants report improved health	5%	9%

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Downtown Streets Team, Inc.

Program Title	Sunnyvale Street Team Volunteer Program	***Recommended Amount:*** DNF
Program Abstract & Target Population	Case Manager provides case management and employment services and workshops for clients actively experiencing homelessness or at-risk of homelessness in Sunnyvale.	
Agency Description & Address	1671 The Alameda suite 301 San Jose, CA 95126 www.streetsteam.org The mission of Downtown Streets Team (DST) is to restore dignity, inspire hope, and provide a pathway to recover from homelessness. DST's programs involve building teams comprised of individuals who are homeless or at risk of becoming homeless and assisting them to rebuild positive work habits, expand their skill set, and overcome barriers as they work towards permanent employment and housing.	
Program Delivery Site(s)	• Staff Office: 1160 Kern Ave., Sunnyvale, CA 94085 • Main Office: 1671 The Alameda Suite 301, San Jose, CA 95126 • Workshops & Success Meetings: 477 N. Mathilda Ave., Sunnyvale, CA 94085	
Services Funded By Grant/How Funds Will Be Spent	• Individual one-hour case management appointments for medical, housing, and employment support • One-hour mental health-focused workshops once per cohort • Weekly office hours for assistance with applying for insurance, scheduling medical appointments, or providing laptop access for virtual therapy sessions • Weekly employment readiness workshops covering resume building, interview preparation, and job search strategies • Weekly self-growth workshops focused on confidence-building, goal-setting, and financial literacy • On-site wellness check-ins with a nurse or healthcare provider once per cohort • Referrals to Valley Homeless Health Care Program (VHHP) mobile services for medical, dental, and mental health support • Access to “Backpack Medicine” program referrals for after-hours healthcare needs • Health and wellness kits provided quarterly, including hygiene products, first aid supplies, and wellness resources • Group therapy sessions in partnership with local mental health providers (bi-monthly) • Nutrition and meal-planning workshops once per cohort to support overall health and well-being	
Budget Summary	Full requested amount funds $50 stipends to participants who attend weekly meetings and workshops, as well as some administrative costs.	
FY2026 Funding	FY2026 Requested: $25,300	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Downtown Streets Team, Inc.

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FY2026 Dual Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF	
Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	Did Not Apply in FY2024	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 100%

	Metrics	***6-month Target***	***Annual Target***
FY2026 Proposed Metrics	Individuals served	20	40
	Services provided	20	40
	Number of hours of training provided to program participants	80	160
	Opt in to sign up for health insurance	20%	30%
	Opt in to receive case management in order to achieve their goals	25%	50%

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Helping Hands Silicon Valley

Program Title	Emergency Respite & Supportive Services Program	***Recommended Amount:*** $20,000
Program Abstract & Target Population	Volunteers will provide immediate and flexible support services to unhoused or those at risk of becoming unhoused, such as emergency motel stays during inclement weather or medical emergencies, transportation assistance to healthcare appointments, and access to essential resources like food and clothing. 99% of their clientele are 200% below the federal poverty line.	
Agency Description & Address	1591 Goldfinch Way Sunnyvale, CA 94087 https://www.helpinghandssv.org/ Helping Hands Silicon Valley's (HHSV) mission is to empower and uplift the most vulnerable in our community by providing comprehensive support, resources, and opportunities that foster self-sufficiency and promote thriving, independent lives. A central part of our approach is building and maintaining relationships with clients. We listen, foster trust and friendship, and slowly mentor each person towards the next small step. By maintaining consistent contact with the client, we aim to build their confidence in HHSV as a resource, providing timely and reliable support. Our trained team bridges critical service gaps by providing rapid, flexible aid, enabling clients to access healthcare and work towards self-sufficiency. We prioritize fostering pathways to lasting independence, addressing the health and stability of the most vulnerable in our community.	
Program Delivery Site(s)	• We provide street based outreach services. The locations where we will provide services will be in the cities of Sunnyvale, Cupertino and Mountain View. Some locations can be Sunnyvale Public Library and Sunnyvale city parks among other public spaces.	
Services Funded By Grant/How Funds Will Be Spent	• Proposed Services: o Street outreach to identify client needs, 2–3 hours per week o Comprehensive 1 hour assessments to triage client needs, as required o Coordination of transportation to medical appointments, as needed o Arrangement of emergency motel stays during inclement weather or medical crises o Assistance with scheduling medical appointments o Distribution of phone battery packs for clients o Payment of phone bills for clients, when necessary o Provision of essential items (e.g., hygiene kits, clothing) to support well-being, 2 hours per week o Food distribution, 4 hours per week	
Budget Summary	Full requested amount funds partial salary for a program assistant with majority of costs going towards supplies/consumables such as motel rooms, bus passes, transportation to appointments, battery packs, phone bills, food, clothing, etc.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $20,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Helping Hands Silicon Valley

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	90	150
	Services provided	500	1,400
	Number of individuals with improved living conditions as a result of services provided	90	150

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Hope's Corner Inc

Program Title	Healthy Food for Hope	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Purchasing fresh fruit, fresh vegetables, milk, lean protein, and other nutritious food for the program team and volunteers to provide nutritious meals for homeless and food insecure individuals located at agency site, the Day Worker Center and Safe Parking lot locations.	
Agency Description & Address	748 Mercy Street Mountain View, CA 94041 https://hopes-corner.org Hope's Corner provides free healthy meals, hot showers, laundry service, refurbished bicycles, clothing and toiletries, advocacy, and linkages to resources to seniors, adults, and children in need within our community in a welcoming environment. Hope's Corner collaborates with other organizations, including Community Services Agency (CSA); Second Harvest of Silicon Valley; Peninsula Food Runners; Replate; Stanford Flu Crew; Seeds of Hope; The United Effort Organization; and Silicon Valley Bicycle Exchange as well as local businesses to provide services that improve the lives and health of homeless, low-income, and vulnerable individuals in Mountain View and adjacent communities. Through the programs and services, they provide dignity to underserved members of the community, provide meaningful connections, and offer them hope for a better future.	
Program Delivery Site(s)	• Mountain View Campus of Los Altos United Methodist Church (LAUMC) - 748 Mercy Street, Mountain View • Day Worker Center of Mountain View - 113 Escuela Avenue, Mountain View • MOVE Mountain View Safe Parking lots: o Shoreline Lot: Shoreline Amphitheater Lot B, Mountain View o Terra Bella Lot: 1020 Terra Bella Avenue, Mountain View o Evelyn Lot: 79 East Evelyn Avenue, Mountain View	
Services Funded By Grant/How Funds Will Be Spent	• Hot breakfasts and to-go sack lunches – Mondays and Wednesdays (8 – 9 a.m.) and Saturdays (8 – 10 a.m.). • Hot meals delivered or provided to RV residents – after Wednesday and Saturday breakfasts and on Monday and Thursday evenings; similar food as Saturday breakfast • Hot meals provided to the Day Worker Center – after Saturday breakfasts • Hot meals provided to HomeFirst Cold Weather Shelter residents; similar food as meals for RV residents • Health information provided at onsite meals in English, Spanish, and Mandarin	
Budget Summary	Full requested amount funds the purchase of nutritious food.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met:97%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 100%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	44	52
	Services provided	1,800	3,600
	Number of individuals connected to a sustainable source of healthy food (CalFresh/SNAP, food banks, etc.)	44	52

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Mountain View Police Department

Program Title	Dreams and Futures- Mountain View Police Department's Youth Services Unit	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Youth counselors provide summer enrichment program at Mountain View High School and various field trip sites for underserved 4th through 8th grade youth residing in Mountain View and/or enrolled in Mountain View Whisman School District who are at high risk for violence and/or involvement in gangs, drugs and/or alcohol use.	
Agency Description & Address	1000 Villa Street Mountain View, CA 94041 https://www.mountainview.gov/our-city/departments/police The Mountain View Police Department's Youth Services Unit sponsors the Dreams and Futures Summer Program. The Dreams and Futures Program was created in the summer of 1996 as a gang prevention program. Since its creation, the program has grown to more than just a gang prevention program to include underserved children in Mountain View who qualify for a variety of reasons. The program services youth within the community and promotes healthy nutrition, physical activity, and healthy minds through various educational blocks of instruction. The Dreams and Futures program promotes continued education to prevent summer learning loss and promotes positive interactions between police and youth as well as other community partners.	
Program Delivery Site(s)	• Mountain View High School, 3535 Truman Avenue, Mountain View, CA 94040 and various field trip locations.	
Services Funded By Grant/How Funds Will Be Spent	• Our program emphasizes teamwork, self-esteem, and decision-making, and communication skills to help youth believe in higher education and take a strong stand against drugs, alcohol, and gangs which include: • Program is two, 2-week sessions during the summer. One for grades 4th-5th and one for grades 6th-8th. • Workshops include conflict resolution, participatory educational activities, classes in writing and computer skills, and fitness/sports camps (e.g., soccer and basketball) that are coached by police, community volunteers, and youth mentors. • Twice a week youth take educational field trips (e.g., The Tech Museum) to excite them about learning and acquaint them with their broader community. • We provide a healthy breakfast, lunch, and snacks as many of our participants come from families where there is insufficient food. • We teach about healthy lifestyles and good nutrition that addresses their future risk of obesity and diabetes. • Participation is free.	
Budget Summary	Full requested amount funds partial salary for youth counselors as well as some costs for healthy meals and snacks, academic supplies/incentives and field trips.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $30,000 FY2025 6-month metrics met: 94%	FY2024 Approved: $25,000 FY2024 Spent: $25,000 FY2024 Annual metrics met:97%	FY2023 Approved: $25,000 FY2023 Spent: $25,000 FY2023 Annual metrics met: 95%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	54	54
	Services provided	486	486
	Number of individuals with improved living conditions as a result of services provided	54	54

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Rebuilding Together Peninsula

Program Title	Safe at Home	***Recommended Amount:*** DNF
Program Abstract & Target Population	Rebuilding Together Peninsula (RTP) staff along with some subcontractors will provide necessary home repairs for low-income seniors many of which have disabilities.	
Agency Description & Address	841 Kaynyne Street Redwood City, CA 94063 www.rebuildingtogetherpeninsula.org Rebuilding Together Peninsula's mission is "Repairing homes, revitalizing communities, rebuilding lives." For 36 years, Rebuilding Together Peninsula (RTP) has been the primary agency thousands of low-income neighbors across the Peninsula have turned to for critical repairs and improvements to help them continue to live in safe and healthy homes. RTP has built the expertise and infrastructure to effectively address the repair needs of San Mateo and northern Santa Clara counties' low-income homeowners. Our reputation as experts in rehabilitating and preserving homes for those having to choose between paying for groceries or critical home repairs has made us the trusted resource for local families facing such challenges. Today, with support from skilled staff and 1,000 volunteers, RTP completes approximately 150 repair projects annually.	
Program Delivery Site(s)	• Repairs are provided at the home of low-income homeowners in Mountain View and Los Altos.	
Services Funded By Grant/How Funds Will Be Spent	• This grant will support repairs at 14 homes over the grant award year, 12 in Mountain View and 2 in Los Altos. • Each home repair program participant receives five services over a three month period: • 1. Homeowner submits a repair application with income verification requirements; an RTP staff person then reviews and guides the homeowner to complete as needed. • 2. Staff conduct a comprehensive Home Safety Assessment to determine the repairs needed. • 3. Staff develop a Home Safety Plan (aka scope of work) which details how the repairs will be completed. • 4. Repairs and home safety modifications are completed by our experienced repair technicians, trusted subcontractors and/or volunteers. (Note: volunteers perform volunteer-friendly tasks like painting, debris removal and landscaping) • 5. Staff review the project and collect feedback through surveys to assess the impact of our work on the homeowner.	
Budget Summary	Full requested amount funds partial salary for Director of Programs, Safe at Home Manager, Repair Technician and Intake Specialist as well as expenses for construction materials and subcontractor fees.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New Program in FY2026	New Program in FY2026	New Program in FY2026

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Rebuilding Together Peninsula

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	7	14
	Services provided	35	70
	Number of individuals with improved living conditions as a result of services provided	7	14
	90% of homeowners surveyed will report RTP's work made their home a safer place to live.	90%	90%
	90% of homeowners surveyed will report RTP's work made it possible for them to afford to remain in their home.	90%	90%

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Rebuilding Together Silicon Valley

Program Title	Safe and Healthy Homes for Older Adults in Sunnyvale	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Construction Services Program Manager, Repair Technician, Program Director, and Client Services Coordinator to provide home repair and accessibility modifications for low-income older adults in Sunnyvale. 100% of our clients have a household income at or below 80% of the Area Median Income. This request will target low-income older adult homeowners in Sunnyvale who cannot be assisted with federal funding because their home is located in a flood zone and they cannot afford the required insurance; as well as low-income residents who have already utilized the City program and are therefore not eligible for additional services.	
Agency Description & Address	1701 South 7th Street San Jose, CA 95112 https://rebuildingtogethersv.org Our mission is repairing homes, revitalizing communities, rebuilding lives, and our vision is safe homes and communities for everyone. We provide home repairs and accessibility modifications for low-income residents in Santa Clara County, including older adults, individuals living with disabilities, and veterans. These services are provided at no cost to the people we help and are tailored to the needs of each homeowner. We also provide facility maintenance and repairs for nonprofit organizations so they can dedicate their time and resources to helping those in need in our community. Since our founding in 1991, Rebuilding Together Silicon Valley has mobilized more than 43,000 local volunteers who have repaired and transformed over 5,633 homes and community facilities.	
Program Delivery Site(s)	• We will provide services at to be determined residential addresses for low-income homeowners who are older adults in Sunnyvale.	
Services Funded By Grant/How Funds Will Be Spent	• Mobilize teams of staff and volunteers to provide essential home safety repairs and accessibility improvements (8am-5pm, M-F, all year) • Increase the number of repairs and modifications that prevent falls and ensure home accessibility • Increase the number of older adults and individuals living with a disability who experience improved safety, physical health, mental health, independence, economic security, and community connection	
Budget Summary	Full requested amount funds partial salaries of Construction Services Program Manager, Repair Technician, Program Director, and Client Services Coordinator, as well as skilled labor, materials, supplies and other operating costs.	
FY2026 Funding	FY2026 Requested: $30,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	New in FY2026	New in FY2026	New in FY2026

FY2026 Dual Funding	FY2026 Requested: $30,000	FY2026 Recommended: DNF

Dual Funding History & Metric Performance	FY2025	FY2024	FY2023
	DNF	FY2024 Approved: $30,000 FY2024 Spent: $30,000 FY2024 Annual metrics met: 100%	FY2023 Approved: $30,000 FY2023 Spent: $30,000 FY2023 Annual metrics met: 93%

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Rebuilding Together Silicon Valley

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	5	17
	Services provided	30	70
	Number of individuals with improved living conditions as a result of services provided	5	17
	Older adult service recipients who report their overall health has improved somewhat or a lot since completed repairs/modifications.	75%	75%
	Older adult service recipients who report a low or no chance of falling due to completed repairs/modifications.	65%	65%

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Second Harvest of Silicon Valley

Program Title	Alleviate hunger for low-income residents of Mountain View and Sunnyvale by providing easy access to healthy nutritious foods including plenty of fruits and vegetables, high-quality proteins, and healthy grains.	***Recommended Amount:*** DNF
Program Abstract & Target Population	Nutritious no-cost food for low-income food insecure clients located at 28 community partner program sites in Mountain View, and Sunnyvale.	
Agency Description & Address	4001 North First Street San Jose, CA 95134 https://www.shfb.org/ Second Harvest of Silicon Valley's mission is to end hunger in our community. As one of the largest food banks in the USA, working with 400 partners to distribute food, FREE OF COST, to low-income clients in TWO counties of Santa Clara and San Mateo. Additional client services include nutrition education (live workshops/virtual); multilingual toll-free hotline (1-800-984-3663) to connect callers to free food programs in their neighborhood; CalFresh (formerly food stamps) outreach/enrollment assistance.	
Program Delivery Site(s)	11 partner agencies will assist with food distributions at 28 program sites in Mountain View and Sunnyvale. MOUNTAIN VIEW PARTNERS • Community Services Agency of Mountain View and Los Altos - 204 Stierlin Road, Mountain View, CA 94043 (temporarily located at 435 San Antonio Rd, Mountain View, CA 94040 during construction) • Hope's Corner - 748 Mercy St, Mountain View, CA 94041 • Mountain View Hispanic Seventh Day Adventist Church - 342 Sierra Vista Ave, Mountain View, CA 94043 • Mountain View Senior Center- 266 Escuela Ave, Mountain View, CA 94040 SUNNYVALE PARTNERS • Columbia Neighborhood Center - 785 Morse Ave, Sunnyvale, CA 94085 • HomeFirst - 183 Acalanes Dr, Sunnyvale, CA 94086 • Our Daily Bread - 231 Sunset Avenue, Sunnyvale, CA 94086 • Sunnyvale Community Services – 1160 Kern Ave, Sunnyvale, CA 94085 • Sunnyvale School District – 819 W Iowa, Sunnyvale, CA 94086 • The Salvation Army - 1161 S Bernardo Ave, Sunnyvale, CA 94087 • Trinity Church of Sunnyvale - 477 N Mathilda Ave, Sunnyvale, CA 94085	
Services Funded By Grant/How Funds Will Be Spent	• Purchase variety of nutritious foods to distribute FREE OF COST to low-income food insecure clients in Mountain View and Sunnyvale. • All clients will receive nutritious foods, daily, weekly, monthly– at walk-up sites, farmers market-style distributions and through home deliveries (for homebound seniors/adults). • Using Food Locator Tool (https://www.shfb.org/get-food/), clients can search for free food distributions and other services by their preferred zip codes. • Clients can also call in our multilingual toll-free hotline (1-800-984-3663) to access food in their neighborhoods. • BOTH clients AND nonprofit partners will receive food, FREE OF COST.	

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

Second Harvest of Silicon Valley

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Budget Summary	Full requested amount funds the purchase of nutritious food.		
FY2026 Funding	FY2026 Requested: $40,000	FY2026 Recommended: DNF	
Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $40,000 FY2025 6-month metrics met: 99%	FY2024 Approved: $40,000 FY2024 Spent: $40,000 FY2024 Annual metrics met: 99%	FY2023 Approved: $40,000 FY2023 Spent: $40,000 FY2023 Annual metrics met: 94%

FY2026 Proposed Metrics	***Metrics***	***6-month Target***	***Annual Target***
	Individuals served	650	1,300
	Services provided	175,000	350,000
	Number of individuals connected to a sustainable source of healthy food (CalFresh/SNAP, food banks, etc.)	650	1,300
	Food insecure clients who will benefit from food distribution in Mountain View (Zip codes 94040, 94041, and 94043)	26%	26%
	Food insecure clients who will benefit from food distribution in Sunnyvale (Zip codes 94085, 94086, and 94087)	74%	74%

FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

The United Effort Organization, Inc.

Program Title	Self-Sufficiency Program	***Recommended Amount:*** $30,000
Program Abstract & Target Population	Director of Client Empowerment, Client Manager Specialist along with client managers will provide a self-sufficiency assessment to guide their support, goals and case management assistance for the homeless or those at risk of homelessness. 88% of individuals served are 200% below the federal poverty line with 48% reporting no income.	
Agency Description & Address	748 Mercy Street Mountain View, CA 94041 https://www.theunitedeffort.org/ Our mission is to help unhoused people move towards self-sufficiency and find a safe home in our community. Our base and primary service area are in Mountain View, although they do extend our outreach to other cities in Santa Clara County. They offer comprehensive and integrated services to find affordable housing, public assistance programs, resources, and mentors. They also develop and share self-service tools for public use. They invest the time, effort, and mentorship needed to help clients. They "hold their hand," if needed, to help reduce their worry and stress as they navigate a highly complex system together. They collaborate heavily with other organizations to support our clients. The ultimate goal is to house the unhoused while taking care of their overall health.	
Program Delivery Site(s)	• Trinity United Methodist Church: 748 Mercy Street Mountain View, CA 94041	
Services Funded By Grant/How Funds Will Be Spent	• We guide each client to select a pillar to work on • Clients are coached to set SMART (specific, measurable, attainable, relevant, and time-bound) goals, create an action plan, explore why their goals are important, and consider obstacles that might be encountered. • We meet with individual clients regularly to discuss and track progress and, through frequent check-ins, work towards the goals. Check-ins include in-person meetings, phone calls, texts, etc. • Many clients have chosen either Employment and Career or Financial Management as their bridge pillar to work on, and we customize the mentoring to each client's needs, which includes job training classes, job-seeking support, financial coaching, etc. • In the process, we recognize that most clients are estranged from their families or any social network, therefore, we also emphasize Family Stability • We are their champion, confidant, coach, and cheerleader who accompany them on the pathway to self-sufficiency.	
Budget Summary	Full requested amount funds partial salary for Director of Client Empowerment and Client Manager Specialist as well as some funds for an additional license for their self sufficiency program module.	
FY2026 Funding	FY2026 Requested: $75,000	FY2026 Recommended: $30,000

Funding History & Metric Performance	FY2025	FY2024	FY2023
	FY2025 Approved: $25,000 FY2025 6-month metrics met: 100%	New Program in FY2025	New Program in FY2025

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FY2026 Economic Stability Application Summary

Economic Stability
(Including Food Insecurity, Housing & Homelessness)

The United Effort Organization, Inc.

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	Metrics	6-month Target	Annual Target
FY2026 Proposed Metrics	Individuals served	60	80
	Services provided	1,200	1,600
	Number of individuals with improved living conditions as a result of services provided	45	60
	Participants who improve at least 2 points on The United Effort Foundational Needs Assessment and/or at least 2 points on the EMPath Bridge to Economic Mobility Assessment.	75%	75%